RESULTS FOR DEVELOPMENT

Insight Health Advisors

ACCESS health international

Supporting public-private engagement in Kakamega County (Kenya)

Case study

March 2021

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Abbreviations

AHI	ACCESS Health International
AWP	Annual Work Planning
CEC	County Executive Committee
CHMT	County Health Management Team
IHA	Insight Health Advisors
KEMSA	Kenya Medical Supplies Authority
LMIC	low- and middle-income countries
MOU	Memorandum of understanding
MOH	Ministry of Health
MEL	Monitoring, evaluation, and learning
MHS	mixed health systems
MNH	Maternal and newborn health
NHIF	National Hospital Insurance Fund
NGO	Non-governmental organization
PPE	public-private engagement
R4D	Results for Development
RUPHA	Rural Private Hospitals Association of Kenya
SMHS	Strengthening Mixed Health Systems project
SDG	Sustainable Development Goals
UHC	universal health coverage
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Executive Summary

The Strengthening Mixed Health Systems (SMHS) project, led by Results for Development (R4D) and funded by Merck for Mothers, was designed to demonstrate and document practical and actionable processes for integrating quality private maternity care into government-stewarded health systems. The project provided direct support for public-private engagements (PPEs) in maternal and newborn health in two countries, including Kakamega County, Kenya, and Maharashtra State, India. In Kenya, SMHS—led by R4D and Insight Health Advisors Ltd (IHA)—supported a new engagement between the Kakamega County government and private sector providers to improve PPE and the quality of maternity care. The SMHS approach included co-prioritization of key maternal health and health system issues and related PPE challenges. Following this, the proejct supported development and implementation of action plans over a 12-month period to address challenges, with technical and capacity development support provided to public and private actors by IHA.

In parallel to the activities undertaken by R4D and IHA as part of the SMHS approach, R4D designed and led an embedded evaluation and learning approach that sought to answer two core research questions about supporting public-private engagements for maternal and newborn health, including:

1. Is the approach of supporting public-private engagements to strengthen maternal and newborn health and UHC associated with outcomes including improved quality of engagement between the sectors and improvements in relevant health service outcomes?
2. What factors are associated with helping to achieve intended outcomes, and what factors are associated with hindering engagements?

A process evaluation revealed evidence of progress on approximately two-thirds of the actions co-designed and implemented by the involved public and private sector actors. Outcome harvesting revealed additional small and large outcomes that evidence suggests are associated with SMHS. These included broader health system outcomes such as improved referrals and commodity-sharing between sectors and engagement-related outcomes including the appointment of a private sector liaison in the county government and plans to set up private sector associations across all of Kenya's counties.

Our analysis also revealed key factors that may have helped the success of the engagement, including high-level political support, the organization of a private sector association to enable engagement with the county government, the existence of a clear and common goal for engagement, and support of a trusted broker. Hindering factors included political bureaucracy, resource constraints, and a lack of pre-existing policies for PPE. Foundational engagement factors—including willingness to engage, trust, and mutual understanding between sectors—were considered challenges in the baseline, but were framed positively in the endline, indicating that these factors improved as a result of the engagement. We found mixed results on factors such as communication between sectors and the technical and managerial capacities of the sector actors to implement the engagement, as well as the presence of external shocks including COVID-19, political transitions, and industrial strikes.

While not conclusive evidence of impact, the results of the evaluation provide strong signals that even relatively short-term investments have the potential to improve engagement between the public and private sectors and ultimately, lead to improvements in health. We observed more progress on actions that were focused on improving engagement between the sectors—relative to the actions that focused on improving health-related outcomes—indicating that engagement outcomes are likely foundational to improving health-related outcomes and that prioritizing

improvements in how the sectors work together creates greater potential for health improvements in the future. Further, while shocks such as the COVID-19 pandemic and political changes presented challenges to public and private sector actors, we observed resilience and adaptation by partners to utilize the new PPE to combat what could have been crippling challenges to the system. This is further demonstrated by the results of the outcome harvesting, which found outcomes that were different and arguably bigger than what was anticipated at the beginning of the project. We also found that factors influencing PPE are interrelated and dynamic and can be improved as engagement outcomes themselves, indicating that improving the engagement between sectors can improve the effectiveness of the PPE in contributing to other outcomes. Finally, responses to key informant interviews make it clear that the continued capacity building, facilitation, and technical support provided by a third party broker (in this case IHA) was perceived as critical to this work. This points to the immense value for flexible and intensive facilitation by a trusted broker. The role of trusted broker is one that does not exist in many PPEs, but it is one that is worthy of further piloting and study, given the promise that emerged from the SMHS engagement.

Finally, we recognize that 12 months is a short time period in which to see substantive progress on system changes, leading one to question how much time is needed to create a foundation for engagement when one did not previously exist? We observed that there are some actions, factors, and relationships between partners that are likely to be longer-lasting, even after a relatively short period of support. These changes, the foundation for which was set in a short 12-month period, are major milestones that would not otherwise have been met. They demonstrate the significant and far-reaching effect that approaches like SMHS can have in pursuing more effective mixed health systems—and the promise of similar approaches outside of this pilot case.

Introduction

Background

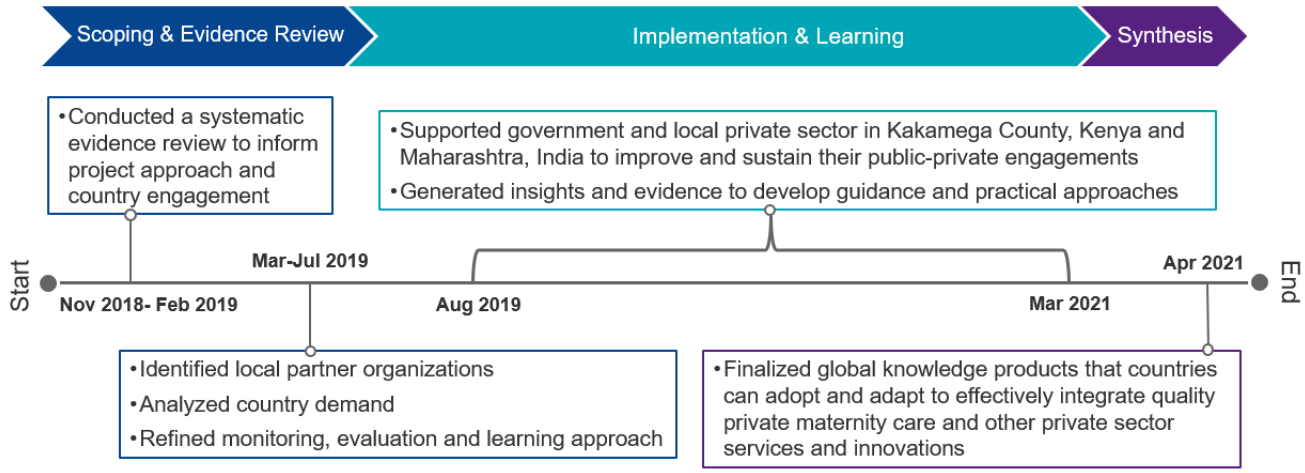
Many countries recognize their limitations in achieving the Sustainable Development Goals (SDGs) and universal health coverage (UHC) through public provision of health services alone — and wish to better engage the private sector to do so. However, country governments often lack information about local private providers and solutions in their countries, do not have a defined stewardship role, and/or are not supported by the appropriate institutional systems and processes to engage private providers in a mixed (public-private) health system (MHS).[1] Similarly, the local private sector in many countries wants to engage with the public sector, but they need government direction on how to engage and how to identify strategic opportunities.

In low and middle-income countries around the world, an estimated 40% of women seek maternal and reproductive health care from the private health sector.[2] This makes cooperation between the sectors vital to improving maternal health and ultimately achieving the SDG targets to lower maternal mortality.

About the SMHS Project

The Strengthening Mixed Health Systems (SMHS) project, led by Results for Development (R4D) and funded by Merck for Mothers, was designed to demonstrate and document practical and actionable processes for integrating quality private maternity care into government-stewarded health systems (**Figure 1**). R4D partnered with Insight Health Advisors (IHA) in Kenya and ACCESS Health International (AHI) in India to support project implementation.

Figure 1. *The SMHS project timeline*



[1] Defined as "a system with goods and services provide by the public and private sector, and health consumers requesting these services from both sectors."
World Health Organization. 2019. The private sector and universal health coverage. https://www.who.int/bulletin/volumes/97/6/18-225540/en/ (29 April 2021, date last accessed).
[2] Campbell OM, Benova L, MacLeod D et al. 2016. Family planning, antenatal and delivery care: cross-sectional survey evidence on levels of coverage and inequalities by public and private sector in 57 low- and middle-income countries. *Tropical Medicine and International Health*. Apr;21(4):486-503.

Starting in November 2018, the project conducted a systematic evidence review to inform the project approach, conducted extensive country scoping and demand analysis – including local partner identification, and developed and refined the project's facilitation and monitoring, evaluation and learning approach. From August 2019 to April 2021, in collaboration with local partners, the project supported governments and local private sector in Kakamega County, Kenya and Maharashtra, India to improve and sustain their public-private engagements (PPEs). In Kenya, R4D partnered with Insight Health Advisors (IHA) and in India, ACCESS Health International (AHI). Throughout implementation, the project generated insights and evidence with the aim of producing global knowledge on the practical approaches that countries can adopt and adapt to effectively integrate quality private maternity care and other private sector services and innovations.

The project was designed around two interrelated but distinct approaches: (1) the provision of direct support and process facilitation for public-private engagements in two low and middle income countries (LMICs) to strengthen the integration of quality private maternal care in these locations and (2) an adaptive learning agenda to integrate both implementation learnings and results from these two cases with the broader evidence base from existing public-private engagements.

The first approach was piloted in Kakamega County in Kenya for a new engagement between the sectors and in Maharashtra State in India on a newly launched program (LaQysha Manyata) seeking to assure and improve the quality of maternity services in the private sector across the state. Ultimately, the processes for improving public-private sector engagement, facilitated by R4D, IHA, and AHI, sought to help country actors move towards achieving UHC and improved maternal health and was tested as a potential model for supporting other countries with the same goals.

The second approach – the project's learning agenda – was designed iteratively to identify and fill evidence gaps in both the existing academic literature and the guidance for policymakers, development partners, and private sector actors seeking to develop or strengthen mixed health systems. Ultimately, the learning agenda was developed to include three key pieces of research: (1) a systematic review of the existing evidence of whether and how MHS can improve health outcomes, (2) two primary cases studies analyzing the programs undertaken in Kenya and India as part of the SMHS project, and (3) secondary analysis of six existing public-private engagements that have been evaluated as part of the existing literature.

This report presents the results and learnings from one of the two primary cases: support for public-private engagement in Kakamega County (Kenya)[3]. We begin with an Introduction to the Approach, Kakamega County, and the Objectives, Research Questions, and Rationale for this component of the research. The next section describes our Approach in Kenya, followed by Methodology for this analysis. We then end with Results and Discussion.

[3] The SMHS Team would especially like to acknowledge and thank Mary Njeri for her excellent work as lead interviewer during the endline data collection in Kakamega County.

SMHS Approach in Kenya

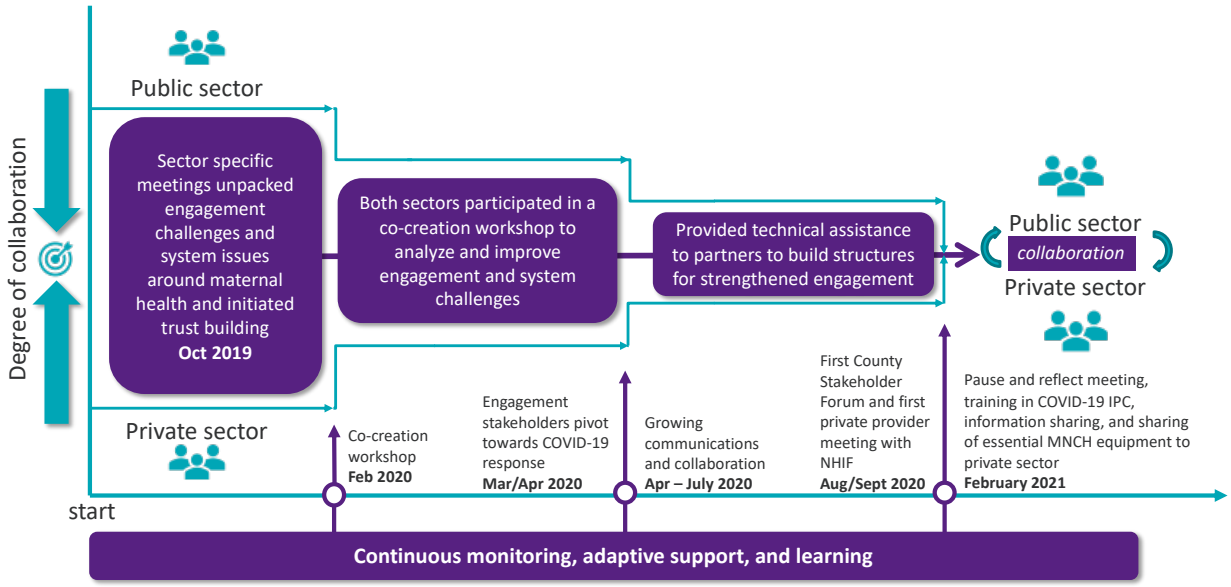
Results for Development and Insight Health Advisors began working in Kakamega County in 2019 following a scoping trip in the country in which several potential target counties were visited. The team selected Kakamega County after conducting interviews from representatives of the public, private, and development sectors from national and several county organizations and institutions. These discussions revealed limited joint planning, budgeting and decision-making between the public and private sectors at the county level; a lack of formal structures for engagement; and a will to engage in programming to support stronger partnership between public and private sector actors with some mistrust and misunderstandings remaining. Based on these discussions, the R4D/IHA team selected Kakamega county for the site of the SMHS project in Kenya.

Approach to supporting public-private engagement in the county

The SMHS approach integrated three distinct but overlapping steps (see Figure 2): sector specific meetings with representatives from the public and private sector in the county, co-creation workshops to analyze and improve engagement and system challenges, and ongoing technical assistance to partners to take actions on engagement and system challenges. These steps are described in greater detail in the SMHS Approach Brief; we describe them briefly here to provide insight to help interpret results presented later in the case study.

After the scoping visit and county selection, Insight Health Advisors began by identifying and holding meetings with representatives from each sector independently. The objective of these meetings was to provide a space in which each sector could provide open and direct input as to the challenges facing both the county health system as a whole and specifically the ability of the different sector representatives to engage with each other to strengthen the overall system. Upon completing these meetings, IHA and R4D utilized the input provided by stakeholders to design a co-creation workshop that would bring together representatives from the county, the private sector and a limited number of development partners. The goals of this workshop were as follows: (1) to build trust and a shared vision across sector representatives to serve as a foundation for further engagement; (2) to co-prioritize key maternal health and health system issues and related public-private engagement challenges; and (3) to support the development of an action plan that partners would carry out based on health and engagement breakdowns that they identified as high-priority during the workshop. This workshop took place over two days in February 2020. Over the next 12 months, public and private sector representatives carried out the actions designed during the workshop along with other priorities that emerged. IHA provided on-going tailored technical support to stakeholders based on needs identified during the workshop and over the 12 months of implementaiton.

Figure 2. *SMHS approach in Kenya*



Introduction to Kakamega County (Kenya)

Kakamega County is located in the western part of the country and is divided into twelve sub-counties. According to the 2015 Demographic Health Survey, Kakamega is in the middle of Kenyan counties in terms of maternal, newborn, and child care indicators, with 48.6% of babies delivered by a skilled birth attendant (ranking 32nd of 47 counties) and 73.1% being fully vaccinated (ranking 29th of 47 counties). Further, according to a UNFPA Assessment from 2016, Kakamega experienced the 5th highest maternal mortality rate among Kenyan counties, according to statistics from 2014.

As in other areas of Kenya, Kakamega is served by a mix of government-run hospitals and primary healthcare facilities and private providers, which include for-profit and faith-based facilities. In addition, several major development partners play an important role in healthcare delivery and programming in Kakamega, including Afla Halisi (funded by USAID and led by Jhpiego) and Tupime Kaunti (funded by USAID and led by Palladium Group).

During the co-creation workshop described above, public and private stakeholders validated common maternal health and UHC challenges, shared and discussed challenges in engaging across public and private sectors, and worked to understand the root causes of these challenges through a root cause analysis. These challenges included: delays in reimbursements from the National Hospital Insurance Fund (NHIF) to public and private facilities; lack of standardized supportive supervision across public and private facilities and variable quality of care in the private sector; and high staff turnover and lack of adequate skilled staff across public and private facilities.

Learning objective and research questions

In parallel to the activities undertaken by IHA/R4D and partners as part of the SMHS Approach, R4D designed and led an embedded evaluation and learning approach that sought to answer two core research questions about supporting public-private engagements for maternal and newborn health:

- (Research Question 1) Is the approach of supporting public-private engagements to strengthen maternal and newborn health and UHC **associated with outcomes including improved quality of engagement between the sectors and improvements in relevant health service outcomes**?

- (Research Question 2) What **factors are associated with improvements** in outcomes, and what **factors are associated with weakened outcomes**?

Ultimately, the learning objective for this work is to surface and share actionable evidence that policymakers, providers, trusted brokers, and others supporting mixed health systems can use to better design and implement public-private engagements that are better able to improve maternal and newborn health and universal health coverage. We designed this project – and specially the monitoring, evaluation and learning (MEL) approach - to overcome this evidence gap using robust methods to generate lessons for how to successfully integrate quality private maternal care into mixed health systems at critical stages of the public-private engagement process.

Methodology

To answer the research questions presented above, we undertook an adaptive and qualitative research design.

Health and engagement outputs and outcomes (research question 1). Beginning with research question 1, we utilized a process evaluation methodology. A type of programmatic evaluation, the process evaluation allowed us to collect data on outputs and outcomes that we would anticipate are associated with each activity undertaken as part of this case and to analyze the degree to which the activity is actually associated with these changes. While not able to assess impact or causation, the process evaluation helped us to understand whether activities were carried out and associated with changes in various outcomes of interest. In practice, the process evaluation involved the collection of data to trace the ultimate theory of change developed for this work (the original version of the theory of change is shared in Figure 2, with changes made to this framework during the program discussed in the Results section).

Data used in the process evaluation were collected from several sources. Our primary data sources included a series of key informant interviews and review of primary data sources. Key informant interviews were conducted both at the start of the program (February 2020) and near its completion (January 2021). Baseline interviews included nine respondents representing both the public and private sector, and endline interviews were conducted with seventeen individuals representing both sectors as well as development partners. We utilized purposive sampling techniques. For the baseline respondents, we sought to identify individuals who were heavily engaged in discussions during the co-creation workshop and thus would have a higher likelihood of staying engaged throughout the project timeline, while endline informants were identified based on actual engagement and role in the SMHS activities. Ultimately, only four key informants were interviewed for both baseline and endline, due to some leadership changes in both the county health management team and among private sector representatives.

Documents reviewed included materials from meetings (agendas, meeting minutes, invitation lists); formal policies, budgets and memos for the county, national representatives, and private sector meetings; transcripts of dialogues from relevant WhatsApp groups; and photographic evidence from meetings. Together, analysis of key informant interviews and primary

documentation was used to assess the progress of each action designed during the co-creation workshop as well as those added subsequently, including evidence of outputs and outcomes achieved and potential reasons for breakdowns in the case of actions that were not completed. This evidence was supplemented by monthly monitoring data collected through discussions with Kenyan partner IHA to serve as validation for findings from the primary data sources.

In addition to tracing actions, we recognized that outcomes beyond those identified as potential results from the action plans may emerge in association with the SMHS project. As such, key informant interview protocols were also designed to collect data needed to conduct outcome harvesting. Using methods described by Wilson-Grau and Britt (2013), all endline informants were asked targeted but open-ended questions about changes associated with the project. This data was then analyzed to identify common potential outcomes that were not otherwise captured in the process evaluation, and follow-on interviews were conducted to substantiate these outcomes. The findings from this component of the MEL approach are presented after the process evaluation findings in the Results section.

Factors helping or hindering engagement (research question 2). Leveraging baseline and endline key informant interviews, we undertook a closed qualitative coding and analysis to identify the factors that program participants identified as either helping achieve SMHS project outcomes or hindering the progress of activities.

The closed coding scheme for factors was developed based on work produced at the beginning of the SMHS project, including a systematic evidence review that used open coding to identify common categories of factors from the existing literature on public-private engagements for maternal and newborn health (MNH). Based on these findings, the project team developed a conceptual framework (Public Private Engagement Ecosystem – Figure 3) that presents a theory regarding the factors that influence PPE effectiveness. An extensive presentation of the ecosystem is presented in the PPE Ecosystem Brief, with a brief description of each factor presented in Box 1.

Figure 2. *Draft SMHS Kenya Theory of Change*

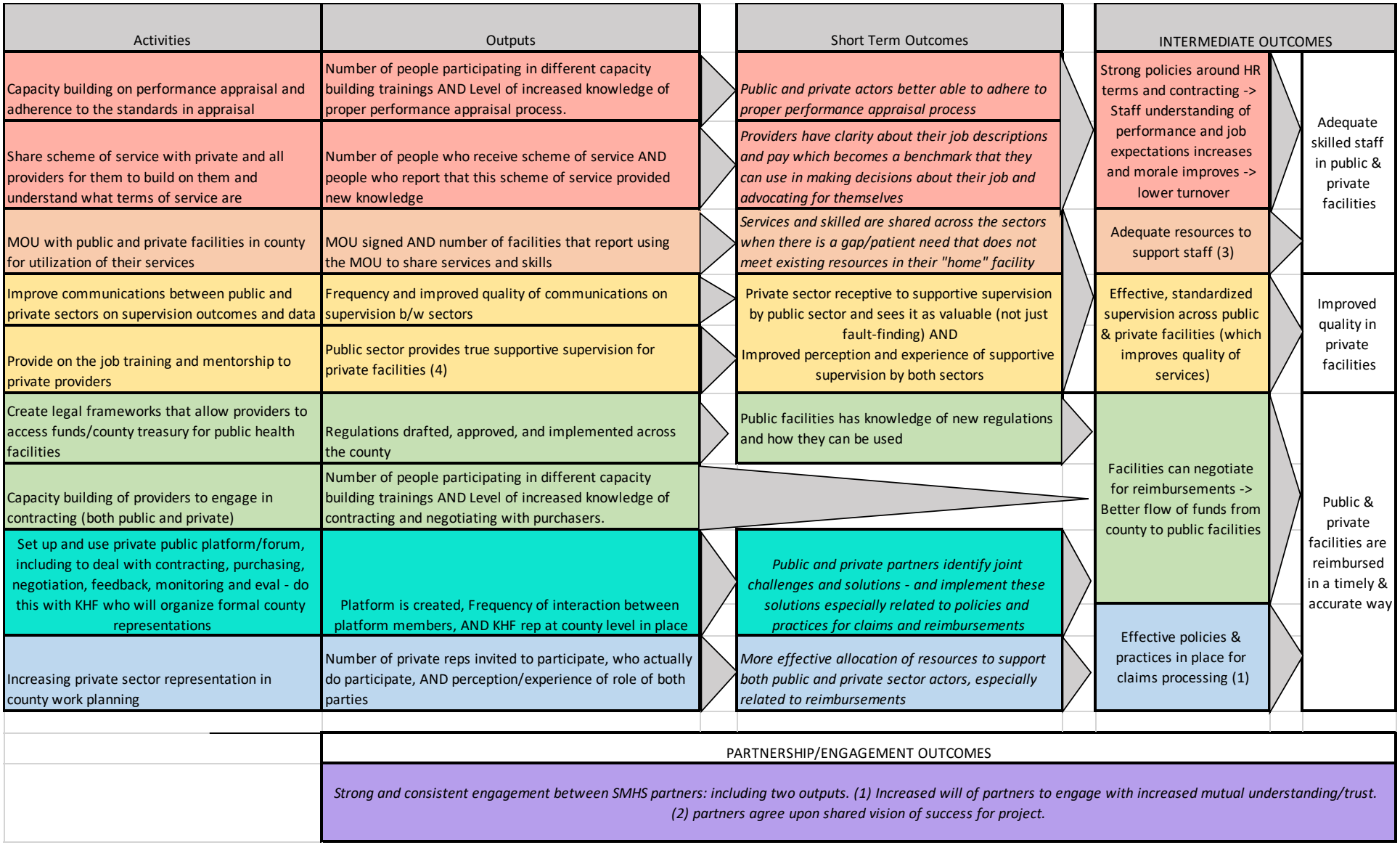
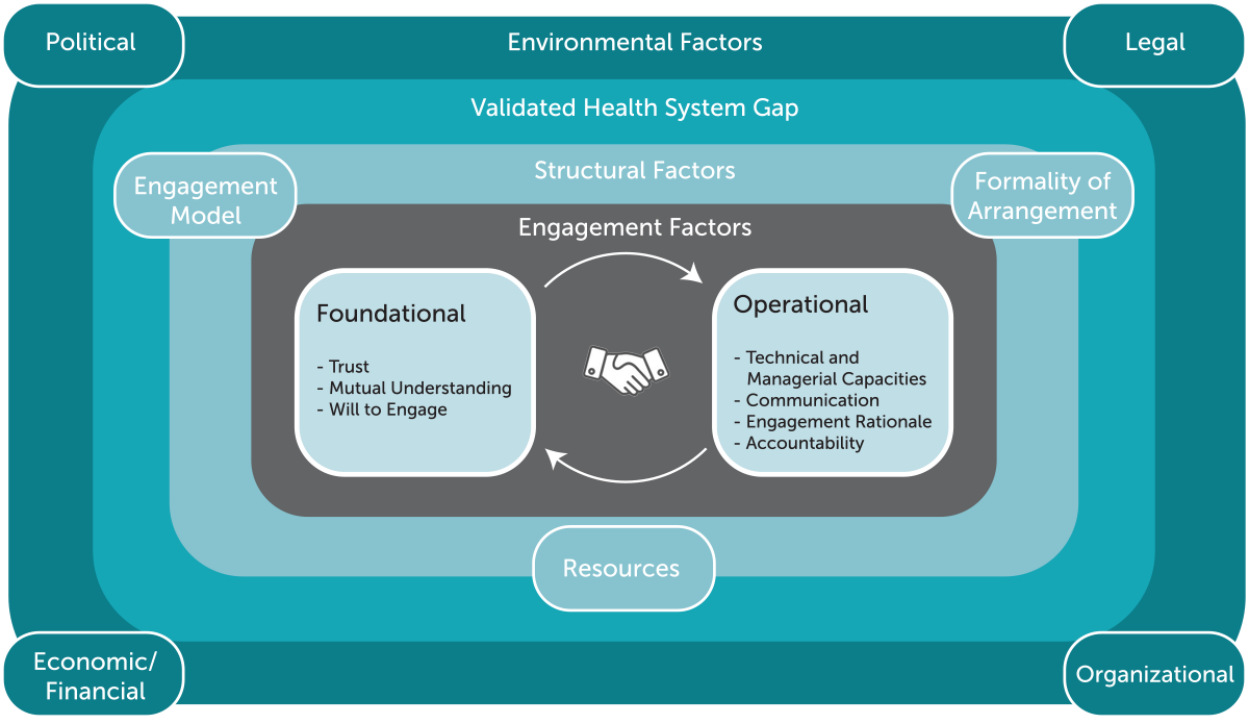


Figure 3. *Public Private Engagement Ecosystem*



Limitations. While these methods provide many valuable lessons and we believe are the best-fit approaches to study a complex systems-focused program such as this one, it is worth acknowledging the limitations of our approach. First, the process evaluation methodology does not allow us to say conclusively whether the SMHS program definitively caused changes in outcomes that we may observe. The results presented reflect this by presenting evidence for correlation or association of program and outcomes. Second, for some actions designed during the co-creation workshop, we only have the perspectives of a limited number of stakeholders to validate these changes. For actions that rely on a small number of perspectives, we note this in the description of results. Third, the stakeholders who we interviewed during the baseline key informant interviews were largely a different set of individuals than those interviewed at endline, due to the fact that there was a changeover in leadership in the county during the project and other transitions. While we are still able to use the baseline as a comparison to general perspectives about the factors, we were not able to conduct direct comparisons between the responses of specific individuals at the start of the project and at the end. Finally, endline data collection plans had to be adapted due to the COVID-19 pandemic and thus the inability of the MEL team to travel to conduct data in-person. We adapted by working with a local researcher; however, this did limit some of our ability to follow-up in person to collect additional data for outcome harvesting.

Box 1. *PPE Ecosystem Factors*

The seven factors are divided into foundational (will to engage, trust and mutual understanding) and operational (communication, engagement rationale, technical and managerial capacities, and accountability). The foundational dimensions include factors central to the relationship dynamics and interactions between the public and private sector actors involved in a PPE, whereas operational factors include factors that support the overall functioning of a PPE.

- Environmental – shaping the environment in which a PPE operates (including political, financial, legal and organizational).
- Structural – defining the architecture of a PPE (including engagement models, formality, and resources for engagement).

- Will to engage - the intention, interest, or commitment of individual PPE actor and their institutions to enter and sustain the engagement.
- Trust - the belief that the opposite sector is acting in good faith and has the goodwill and integrity to effectively participate in an engagement.
- Mutual understanding – the understanding of the opposite sector's capacities, motivations, resources, and role in the health system.
- Communication – the process and approach used by sector partners to exchange information and participate in dialogue.
- Engagement rationale – the basis of and motivation for the engagement.
- Technical and managerial capacities – the capacities of PPE actors related to the technical area of PPE focus as well as project management and joint leadership.
- Accountability – the process and approach used by sector partners to hold one another accountable for carrying out their roles and responsibilities in the PPE.

Results – Health & Engagement Outcomes

Ultimately, we analyzed eleven of twelve actions that were developed or adapted by partners as part of this project. These included four actions that we categorized as "Engagement Actions" (those whose primary outcome relates to improving the ability of the public and private sectors to engage) and seven actions that we categorized as "Health Actions" (those whose primary outcome relates directly to changes in the health system). While some actions could arguably be included in either category, we do find this categorization helpful in understanding the trends in how actions progressed. The final action that was not analyzed is "Public sector provision of supportive supervision to the private sector." We did not analyze the progress of this action because we were informed by partners that no progress was made on this due to the emergence of COVID-19 shortly after the completion of the action plan. Although many other of the original actions were affected by and in some cases adapted in response to the pandemic, this was the only action in which no progress was made at all during the 12 months of the project. A summary of progress across the eleven actions is provided in Figure 4, and explanation of any relevant adaptations from the original theory of change are included in the following sections.

We start below by presenting the results for Engagement actions, followed by Health actions. For each action, we provide context for the action, followed by evidence related to intended outputs and outcomes (from the theory of change), factors that respondents associate with success or challenges, and other outcomes cited by respondents.

Figure 4. *Summary of Progress on Actions*

Share scheme of service with private and all providers for them to build on them and understand what terms of service are	
Improve communications between public and private sectors on supervision outcomes and data, with focus on COVID-19	
Set up and use private public platform/forum	
Establish a private sector association for Kakamega County private providers	
Build capacity of the CHMT to engage and manage relationships with nonstate actors	
Capacity building of human resources of infection prevention and control	
Increasing private sector representation in county work-planning	
Development of capacity building guidelines and protocols for operational management of COVID-19 patients in the private sector	
Capacity building and developing agreement on PPE procurement and disbursement for sectors	
MOU with public and private facilities in county for utilization of their services	
Create legal frameworks that allow providers to access funds/county treasury for public health facilities + Capacity building of providers to engage in contracting (both public and private)	

Action achieved / progress made
Mixed results
Action not achieved / no progress made

Engagement Actions

Formation of a private sector association for Kakamega county

The formation of a private sector association for the county was not included in the original action plans designed during the multi-sectoral workshop in February 2020; however, soon after the workshop, private sector representatives acknowledged that a formal association was critical to coordinate and participate in other actions developed as part of the SMHS engagement. As such, this action was added to the project workplan and became a central part of the SMHS engagement as a foundational engagement action.

Ultimately, the action of forming a private sector association for the county was intended to achieve two key outputs (the creation and registration of the association and increasing the frequency of interaction between private sector representatives). If successful, the private sector association would result in an outcome of the private sector in Kakamega being better represented and enabled to effectively engage with the public sector including as part of the stakeholder forum.

Results. While the action is still in progress, there is strong evidence to indicate that the pursuit of a private sector association improved interaction and collaboration among players within the private sector and (to some extent) with public sector actors as well. Four respondents (all from the private sector) independently confirmed that the registration of the private sector association was progressing and that, while there were delays in finalizing registration in part due to the COVID-19 pandemic, they were confident that the final registration would be completed in the near future in coordination with a lawyer and Insight Health Advisors. Despite delays in completing the registration, the association took several other steps necessary to launch, including the election of interim officials, submission of documents necessary for registration, and reaching out to private clinics and hospitals in the county to invite them to participate.

We were able to confirm the diverse set of private sector association members by reviewing a

list of private sector representatives that was sent to the county health management team SMHS liaison; this list included representatives from each of the twelve sub-counties representing both for-profit and not-for-profit facilities of different sizes including representatives from Catholic and Muslim health services. Interviewees also noted a wide range of private sector actors that were active in the association, including: "*mission hospitals*," "*bigger hospitals*," "*bigger nursing homes, those who are dealing with maternal health*," "*Roman Catholic Church, the Anglican Church, and Muslim community health centres*," and "*ones who dispense and sell medicine, chemists*." We were also able to confirm that the association has a draft constitution, completed in November 2020, which includes association objectives, membership information, management structure, member duties, by-laws, and voting and meeting procedures.

With regard to increasing the frequency of interaction between private sector representatives, the majority of respondents noted that they experienced an increase in communication and engagement with other private sector actors as part of the association. Further, respondents noted that there were further outcomes related to better engagement within the sector, including knowing who else in the county is providing private health services ("*we were scattered, but now at least we are in one room*") and knowing what is happening in different parts of the county.

Ultimately, the private sector association was formed to ensure that the private sector is better represented and enabled to more effectively engage with the public sector. While only one respondent answered affirmatively when asked if this outcome was achieved, all four private sector representatives interviewed cited that they observed changes suggesting that the association increased their voice with government officials. This sentiment is demonstrated by responses such as this one: "*The biggest change I can say is because as we are in one room now, we can face the public. They were our leaders in the county and we have a talk with them. But before as individuals it was impossible*." Another respondent went so far as to also suggest that the public sector recognizes the need to hear from the private sector now, saying: "*Due to the engagement with Kakamega government officials, they have also come to realize that there is nothing they can do without involving the private sector, because we are also giving them indicators of all diseases within the county. So that kind of relationship has built a lot since we formed this association.*"

Further, we observed that the private sector association was able to coordinate to develop a set of requests that they delivered to the public sector regarding "COVID-19 Support"" that was needed. While we cannot confirm that the ten items on this list were provided to the private sector, it is worth noting that the development of this list and delivery to the county health management team PPE liaison (which we can confirm) would have been challenging to achieve without a coordinated private sector structure, which did not exist in the county previously.

After the completion of key informant interviews, we also received a report that the private sector association was continuing to meet, with a recent meeting occurring at the end February 2021 to consolidate all MOUs held by the government with various individual private sector providers (including Caritas, Anglican Development Services, and Muslim services) to ensure all private providers in the county fall under a single memorandum of understanding (MOU), ultimately resulting in greater political clout for the group. This is seen as a critical step in raising the profile of private providers in the county.

Factors. While the evidence suggests that this action was largely successful in achieving its intended outputs and outcomes, respondents noted several factors that may have hindered the progress of this action. Most notably, three of the four respondents highlighted delays caused by the COVID-19 pandemic ("*Because of the Corona we stopped along the way. But we've been communicating we have a wall that we communicate as the stakeholders of the private sector*"). In addition, one respondent each noted that bureaucracy related to registration and a lack of resources for meetings hindered the action. Despite these challenges, one respondent did note that "*goodwill between the public and private sector*" helped both the association and

the relationship between private and public sector actors.

Other outcomes. In addition to the outputs and outcomes that we hypothesized might emerge from this action, respondents highlighted additional outcomes that they observed as a result of this action. Three respondents provided concrete examples of how the private sector is now working more closely together, including consulting more on clinical issues ("… *we now have forums where we meet quarterly or even through whatsapp groups where people will present for example a specific clinical issue and then people are discussing about it. It is more or less on job training through different forums*") and direct sharing of supplies and commodities when needed ("*In case of any shortfalls of some supplies, we've tried to source them within the network to find out who is lacking what and why, therefore, you can be able to really connect that person to the next facility where you can receive the commodities. Especially family planning commodities, vaccines, nets, supply of nets. So those who don't have access to them, we direct them where they can get. They do that.*"). Two respondents also noted increased support and mutual accountability for private sector actors to be receive accreditation. Finally, one respondent each cited the following outcomes: successful "lobby(ing) for inclusion" of "chemists, small health facilities;" developing a forum for communication; and an increased will to engage on the part of both sectors.

A final interview with a representative from a national association to support private sector health actors in Kenya also suggested that the private sector association model in Kakamega county may be seen as a model for the rest of the country, saying: "*We will definitely engage – we are aware that private sector has organized self in Kakamega … And we can look at number one how we collaborate and number two more important how do we use same model to organize similar platforms in other counties.*"

Setting up stakeholder forum for public, private, and other non-state actors

This action was part of the original plan developed as part of the February 2020 workshop with public and private sector representatives, facilitated by the SMHS project. As a part of small group discussions about specific maternal and newborn health challenges during that workshop, the idea of a multistakeholder forum was introduced by two different small groups, one that focused on ineffective financing from the National Hospital Insurance Fund (NHIF) and one that focused more broadly on inadequate funding. Both groups identified the need to develop a stakeholder forum that included government and non-state actors to address these issues. In the months after the workshop as COVID-19 became a larger priority for county and private health providers, the stakeholder forum adapted to immediately address needs in responding to the pandemic in the county.

Recognizing this shift to both focus on COVID-19 immediately and ultimately broaden the topics addressed by the forum, the action sought to achieve three key outputs: establish the creation of the forum, increase frequency of interaction between forum representatives, and ensure a prominent role of private providers in the forum. Based on these outputs, the forum was designed to reach an outcome of public and private partners jointly identifying challenges and solutions and implementing these solutions (especially with regard to COVID-19).

Results. Despite mixed evidence relating to several of the expected outputs of the stakeholder forum, there was general consensus from a diverse set of respondents that the forum did make significant progress on the target outcome – public and private partners jointly identify challenges and solutions and implement these solutions. Respondents from different sectors reported progress made during the stakeholder forum to identify needs for training and capacity building, plans for setting up isolation facilities and other COVID-19 related preparations. These points were all confirmed by the minutes of the stakeholder forum meetings. It is worth noting that, again, some responses referring to private sector partners appear to actually refer to development partners. However, the responses generally suggest that representatives from all sectors participated actively in problem solving and implementation, especially related to

COVID-19.

A diverse set of respondents (7 out of 9 interviewed) confirmed that the stakeholder forum was created and did meet; these respondents included representatives from the public and private sectors as well as development partners. Two respondents reported that they could not confirm that the stakeholder forum had been implemented; however, upon reviewing materials, there is evidence to suggest that these respondents were not involved in the implementation. In reviewing documentation, we can confirm that the stakeholders forum has held at least two meetings, one in June 2020 with 45 confirmed attendees and one in October 2020 with 46 confirmed attendees. We have further evidence that technical working groups, focusing on specific issues, were developed and, in at least one case, met separately (Monitoring and Evaluation Working Group, September 2020). Three respondents noted that the engagement and involvement of encouraging government representatives helped to ensure that the forum was implemented.

While materials from the stakeholder forum meetings confirm that this action did provide several opportunities for actors from different sectors to engage, respondents provided mixed feedback regarding whether the forum did increase the frequency of communication between partners. Notably, the two private sector respondents who spoke about this stated that the forum did not increase frequency of interaction and cited COVID-19 restrictions as the reason why. Public sector and development sector respondents were more positive, noting that frequency of interaction did increase while still highlighting that this was challenging and largely virtual due to the pandemic.

There were similarly mixed responses with regard to the prominence of private sector actors in the stakeholder forum. Several respondents confirmed that private sector representatives participated in the forum, a fact that we confirmed in reviewing minutes from stakeholder forum and technical working group meetings. One public sector representative noted: "*now whenever we engage we have space for the private sector representatives, it's known who they are. The fact that they have organized themselves as many as they are to a kind of organization that has made that easy to achieve*," and a development partner went further to state: "*one thing that came out clearly is that they (private sector) were able to raise up their voice, they were able to speak out their needs and point out issues that they need.*" However, others were more cautious in their assessment of the private sector role for different reasons, including: receptivity from the public sector ("*they still have more to offer that the department has not been open to such as utilizing private sector services due to logistical issues*") and tone/role of the private sector *("… it was more like the private sector was still at a level of advocacy- that they would like to be engaged more and all that. I think from the little that we had, it's still not very clear that this is your [the private sector representatives'] role*").

One possible reason for these differing responses is that it is not clear that all respondents define the private sector in the same way, with some noting the prominence of development partners which may be conflated with smaller private sector actors. Demonstrating his possibility, one public sector respondent expressed the prominent role of the private sector in forum discussions, stating: "*The prominence like especially among the partners, the most prominent has been Ampath. And there's this other one which has been donating equipment- Afya Halisi, they even donated ventilators, 10 ventilators, plus other maternal/newborn equipment which we use in the newborn unit assisting babies who are underweight and those who are breathing problems*."

While the intended output of the private sector having a strong voice in the forum may not have been fully realized yet, there is a good evidence that this is the intention and mandate of the stakeholder forum. The forum terms of reference explicitly note that the forum is to: *"(p)rovide mechanism for the CHMT* (County Health Management Team) *to review availability of service delivery available within the county including in the private, faith based and not for profit sector and liaising with these partners to deploy these resources to meet current and emerging health*

service's needs" as well as "(*p)rovide a mechanism to coordinate the function of all partners in healthcare including private, faith based and not for profit sector towards meeting the counties plans.*" Further, minutes from the M&E technical working group confirm that a private provider is one of the officers of the working group, suggesting some authority and prominence in role.

Factors. Respondents noted several factors that either helped or hindered progress in setting up and implementing the stakeholder forum. On the positive side, two people (one public sector and one private) highlighted the importance of having an organized private sector to help ensure representation in the stakeholder forum. In addition, one person noted that each of the following factors helped improve the effectiveness of the forum: joint accountability of the different sector actors, influence and will of higher level political actors, and coordination and joint work-planning across the sectors. On the other hand, two people cited the change in county leadership in the early days of the project as presenting a challenge, at least initially.

However, most of the factors cited by respondents were more nuanced. COVID-19 was noted as a hindering factor by many respondents, but one person noted that the pandemic helped to energize the forum, providing both a focus and a need to respond collaboratively. Conversely, most people noted that there was helpful will to engage on the part of the government, but one private sector respondent noted that this will did not extend to budgeting to support the stakeholder forum.

For several factors, respondents highlighted the dynamic nature of these issues, both as factors that can influence the outcomes of the actions but that were also influenced themselves by the stakeholder forum. For example, several respondents noted that, while some in the forum may not have started with adequate mutual understanding of the roles and potential contributions of the other sector(s), partners were able to improve their mutual understanding as a result of forum discussions and engagement. Communication and third party support for the forum were also cited both as factors that both strengthened the forum and that may need to be enhanced further to ensure continued success. In the case of third party support, the technical and coordination support from the partner was largely cited as important and helpful whereas financial support was a factor that was cited as a factor that was lacking but needed.

Other outcomes. Many of the other outcomes cited by respondents align broadly with outputs and outcomes that were identified as likely results from this action, including increasing the voice of the private sector (4 respondents representing all sectors) and stronger joint work-planning and relationship between the sectors (6 respondents representing all sectors). In addition, several comments were made about the improvement of soft engagement factors, such as trust and will to engage (4 respondents representing all sectors) as well as accountability (1 development partner representative).

Beyond soft factors and those direct results of the stakeholder forum, several respondents also noted concrete activities that occurred as a result of the forum that allowed them to operate more effectively; these included sharing of materials and supplies across the sectors (3 respondents representing the private and development sectors) and improved reporting and supervision across sectors (4 respondents representing all sectors). Further, while the stakeholder forum largely sought to strengthen engagement across sectors, two respondents highlighted the potential of the forum to introduce and engage other public sector departments to improve internal government coordination. Finally, there were several outcomes cited by a single respondents, including: direct strengthening of staff and infrastructure, improved insight for partners regarding where they can best provide support, and better rapid response to COVID-19 needs.

Increase private sector representation in county work planning, especially for COVID-19 response

The third engagement action agreed on by the public and private sector partners at the February 2020 workshop was to increase private sector representation in county work planning. At the time of implementation, Kakamega County was conducting its Annual Work Planning (AWP) process, and with the advent of the COVID-19 pandemic in Kenya, this action was adapted slightly to include a focus on work planning for Kakamega County's COVID-19 response. The action was intended to lead to three outputs, including (1) more private sector representatives being invited to participate in county work planning activities; (2) the actual participation of private sector actors in those activities; and (3) improvements to both sectors' perceptions of the AWP process. Ultimately, the action was intended to lead to the outcome of private sector inputs and requests being integrated into the Kakamega County COVID-19 response work plan.

Results. A total of 9 key informants were interviewed about this action, including 5 public sector respondents, 2 private sector respondents, and 2 development partner respondents. Generally, most (7 of 9) respondents agreed that this action had been implemented but not completed, as the work plan had not been finalized at the time of the interviews. As stated by one public sector respondent, *"I would say it achieved partly. Partly because we have been with them when we are doing this workplan. We have been working with our private practitioners. Why I am saying partly, is because our workplan is not finished and signed. Otherwise we've been with them."* In terms of private respondents, one agreed that the action had been implemented and the other disagreed, indicating that private provider experiences with this action may have been mixed.

Respondents who reported that this action was implemented also agreed that private sector representatives had been invited to participate in county work planning activities. However, there was less agreement around whether private sector representatives actually participated. One of the two private sector respondents reported that they had participated in county work planning activities and provided inputs related to their budget and activities. Most public sector respondents agreed that private sector representatives participated at least minimally in work planning, but it is worth noting that 2 of the 5 public respondents did not know whether private sector representatives had participated or conflated the participation of private health providers with that of development partners, further highlighting that their participation may have been minimal.

While we reviewed additional evidence, including documentation of the AWP development process, findings on the actual participation of private sector representatives remained inconclusive. Evidence showed that the county budgeted for data collection on stakeholder priorities and validation with stakeholders, and that an AWP validation meeting was scheduled for November 2020—however, there is no concrete evidence of which stakeholders participated. Despite this, reports from Insight Health Advisors did confirm that private sector representatives were given the opportunity to input their service delivery targets into the AWP and that private sector representatives were present during AWP strategy development meetings.

In terms of improvements to both sectors' perceptions of the AWP process, there was general agreement across public sector actors that the action had improved their perceptions of the private sector and the value of including them in county work planning activities. The three public sector respondents who agreed that private sector actors had participated in work planning activities shared improvements to relationships between sector actors and their own knowledge of private sector activities, demonstrated by responses such as the following: *"For us, we have seen we need them. Yeah, we need those colleagues from the private sector in our work planning, so that they can be able to own, so that we are together, we are doing the same things not that we are doing parallel activities. Same activities. And even the support is faster."*

Finally, regarding the outcome of integration of private sector inputs and requests into the AWP, there were some reports from public sector respondents that private sector inputs and requests

were at least partially addressed through adjustments to the county work plan and activities. One public sector respondent reported that while some private sector requests were addressed—such as private sector inclusion in capacity building activities—the county's ability to integrate all requests was constrained by limited public resources. One development partner shared that *"So if you look at the COVID-19 work plan for the county and the budget had a lot of inputs, because they were adjustments on some of those things. The initial workplan only looked at the needs of the government sector."* However, it was not clear whether this was referring to the integration of inputs from private health providers, or just development partner inputs alone.

Given this, it is again worth noting two limitations: first, the lack of evidence from private sector actors themselves, both on any changed perceptions of the AWP process and on the integration of their inputs; and second, the possible conflation of provider providers with development partners.

Factors. Respondents identified several factors that may have hindered the effectiveness of this action. The most frequently cited factor was COVID-19: four respondents (including two public respondents, one private respondent, and one development partner) shared that COVID-19 restrictions made it difficult for sector actors to meet frequently enough for the work planning process, with some meetings cancelled or postponed due to the pandemic.

Constrained resources were also mentioned by one public sector respondent and one development partner as a hindrance. As described above, limited government resources hindered the county's ability to respond to all private sector requests. A development partner also shared that annual work planning as a whole was underfunded, and that there was a need to engage partners to support the process.

Finally, one public sector respondent shared the perspective that different ways of working and bureaucracy across both sectors had hindered meaningful private sector participation, which they framed as "minimal". One private sector respondent also referenced third party support from Insight Health Advisors as a significant helping factor in the work planning process.

In addition to these helping and hindering factors, some respondents also spoke to factors that were improved as a result of this action. As described above, public sector respondents reported improved perceptions of the private sector and the value of including multiple stakeholder voices in work planning activities; this may have had a positive impact on the rationale for the engagement, as actors from both sides expressed that working together helped them to understand their shared goals. Respondents also reported that working together helped to improve communications between sectors, including data sharing from the private sector, and that the private sector was now generally more willing to engage including for supportive supervision.

Other outcomes. When asked about other outcomes that resulted from this action, the most common responses related to the improvements described above about perceptions across sectors and engagement factors such engagement rational and communication. In addition to these, two development partners shared that they thought the county's priorities and work plan was better aligned with evidence-based needs, since with the inclusion of the private sector the county was able to better understand the full picture of the health situation in Kakamega County. Another outcome flagged by public sector respondents was commodity sharing across the public and private sectors, as well as improved referrals and sharing of services especially in the context of the health workers' strike.

Build the capacity of the CHMT to engage with the private sector

This action was not part of the original action plan developed by public and private sector actors during the February 2020 workshop. As the original action plan was implemented—including

adaptations in response to the COVID-19 pandemic—the SMHS partners recognized that for effective implementation, the county CHMT needed to be enabled with strong capacity development support for private sector engagement. Thus, this action was added as part of the adapted action plan, with capacity development support provided to the CMHT by IHA.

The capacity development support was specifically designed to support the CHMT with county health County Executive Committee (CEC) leadership transition, including briefing new leadership on the SMHS project to garner support and align with their priorities; private sector engagement in county AWP and health strategy planning processes; and set-up and structure of the stakeholder forum and associated technical working groups. This action was intended to produce two outputs, including (1) CHMT members receiving one-on-one management training, and (2) types of management training received (e.g., agenda setting, meeting preparation, etc.). Ultimately, this action was intended to lead to the outcome of the public sector being enabled to engage more effectively with private sector actors, including an increased sense of responsibility and improved public-private dialogue via the stakeholder forum.

Results. A total of five public sector respondents were interviewed about this action. Overall, there were mixed reports on whether the respondents had received capacity development training from IHA. Of the five respondents, one reported that they did not receive training from IHA; two reported that they did not receive training from IHA but described trainings held by other partners such as the World Bank; and two reported that trainings from IHA had occurred, though they themselves did not attend. One of these two reported that a member of the CHMT had attended a week-long training in Kisumu on public-private partnership management, though this was not delivered directly funded by SMHS.

It is important to note that these results may have been biased due to the phrasing of the interview question, which asked whether respondents or other CMHT members had received "training" from IHA. Given the responses, it is possible that the respondents interpreted "training" in a more formal way, i.e., as the delivery of a specific curriculum taking place in the form of an event or workshop. While it is not certain that this bias occurred, four of the five respondents referenced outputs and learnings that implied that they did benefit from IHA capacity development activities and on-the-job mentorship. One of these respondents also described the on-the-job mentorship directly: *"We have had recurrent I'll call it mentorship sessions, by IHA to us in groups and as individuals on the design of how to structure this engagement almost on a monthly basis."*

Another described some of the content of the mentorship: *"The premise of the training was the things we've been assuming they are things we may not really know how to handle because of how we've been brought up in the public health sector and we've always had these stereotypes. That private sector is really about cash, a private sector is about, it's about this. So it was important for us to have a common understanding for us to come out of our own cocoons and stereotypes and presuppositions about others, particularly private sector to just come and see okay, after moving out of that, how do you engage this person?"*

These respondents answered positively when asked whether this action achieved the outcome of enabling the public sector to engage more effectively with private sector actors, including an increased sense of responsibility and improved public-private dialogue. Respondents implied that—though still a work in progress—these improvements were demonstrated through the stakeholder forum and virtual engagements with private sector actors; another shared an example of improved management of county development partners.

Three respondents reported that the capacity development support improved their approach to private sector engagement and helped with restructuring of the stakeholder forum, as demonstrated in the following quote: *"Yeah, so it helped us in a way to restructure. Right from our thought process of our stakeholders, to get a broader view, not just partners. And to keep an updated database of our stakeholders, and even to revive the quarterly stakeholder*

engagement forum which had taken a break." Another stated that *"The engagement between public and private sector improved. Especially the key people in CHMT working with the stakeholders and program officers who have engaged with private sector."* Two respondents also reported a new sense of openness to working with the private sector, similar to the above findings on factors related to engagement rationale, willingness to engage, and joint planning.

Factors. While it appears that significant progress was made on this action, one respondent—who reported that they did not receive training from IHA—identified several factors that may have hindered its effectiveness. These were primarily focused on the fact that IHA operated from Nairobi and did not have a local office in Kakamega County, which the respondent felt negatively impacted communication and coordination between IHA and the CHMT. COVID-19 may have also had an impact on communication and coordination between these actors, as it was reported that many interactions were virtual.

Respondents also shared reflections on factors that were more nuanced, in that the factors themselves were influenced by the capacity development support. When asked about factors, all five respondents shared positive impacts on factors related to engagement rationale and will to engage of the public sector, as demonstrated through the following quote: *"Engagement highlighted areas where we could leverage on each other, as the government side we feel more strongly that partnering with private sector could be beneficial to us."* One respondent also shared that private sector engagement, supported by the CHMT receiving capacity development support, led to improved joint planning between sectors.

Health Actions

Human resources capacity building on infection prevention and control (including support from development partners for training)

This action was not part of the original action plan developed during the February 2020 workshop; however, with the emergence of COVID-19, this action was added as a new health-focused action as part of the project's pivot to address the pandemic. This capacity building action was intended to achieve outputs including (1) the participation of public and private actors in capacity building trainings and (2) increased knowledge of infection prevention and control. If successful, this action was designed to result in outcomes including better adherence of public and private actors to proper infection prevention and control protocols. In the longer term, this action was also intended to contribute to improved capacity of private providers to effectively manage COVID-19 patients and systems for training and capacity building of public and private providers, including through development partner support.

Results. It is important to note that only two respondents were interviewed for this action, including one public sector representative and one development partner. Evidence is therefore limited to the perspectives of these two individuals and review of a limited number of documents that relate to this action.

Both the public sector representative and the development partner indicated that they had not been directly involved in implementing in this action, limiting the amount of information they were able to provide. However, both reported that they believed the trainings had occurred and were implemented by Ampath and/or Red Cross. The indirect nature of the available evidence is demonstrated by this response from the development partner when asked whether or not this action had been implemented: *"It did. It was through Ampath plus. I'm sure they must have touched on it."*

While there was agreement that trainings occurred, it remained unclear which public or private actors were involved with these trainings. The public sector respondent mentioned that both

government and private actors were trained but did not specify whether those private actors were private providers or development partners. They also reported that people trained at the county level were then expected to train others at sub-county and facility levels. However, it was not clear who was trained at the county level and whether those trained then went on to conduct additional trainings. The development partner did not directly reference training of private providers but reported that surveillance workers were trained and were supposed to then reach out to community health workers. The public sector respondent did share that some faith-based organizations received support from CHMT members to ensure that COVID-19 protocols were followed, though it was unclear whether this was directly related to the trainings.

While additional review of available relevant documents did little to clarify what occurred with this action, we confirmed that private sector actors shared a list of requests with the county that included capacity development activities related to COVID-19. A review of the county's COVID-19 response budget showed line items related to COVID-19 capacity development activities, but also demonstrated a lack of county budget allocation to those line items and large budget shortfalls, despite some modest budget allocations from development partners.

Despite the lack of clarity around the details of the trainings including who participated, both the public sector and development partner respondents felt that knowledge of infection prevention and control had increased among recipients of the trainings. The development partner reported observing increased knowledge among health workers and sensitivity to COVID-19 safety: *"You look at how health care workers are carrying themselves and you can see there is a difference, people are more sensitive. Initially, it was like this thing might not really be there. I would go to meetings and I used to find mask wearing very… But nowadays, I'm so comfortable with it. I'm so sensitive even when I leave the car. I will check for my mask."*

Regarding the outcome of better adherence to infection prevention and control protocols by public and private actors, the public sector respondent reported that adherence had improved. While the respondent did not specify whether they were referring to public facilities, private facilities, or both, this included adoption of COVID-19 prevention protocols, use of [hand] washing stations, screening within facilities, management of critical clients, home-based care, and psychosocial support. Similarly, the development partner felt that the capacity of private sector providers to effectively manage patients with COVID-19 was improved as a result of the trainings.

Factors. One factor was identified that may have hindered the implementation or effectiveness of this action: lack of resources. As mentioned above, there was a lack of county budget allocation to the trainings, resulting in large funding shortfalls in the budget relative to the total amount needed to execute on capacity development activities. Further, one respondent reported resource constraints, potentially of private sector actors, when asked whether the trainings had increased their capacity to manage COVID-19 patients: *"I believe it improved because the only challenge that was existing could have been in terms of the materials to use, but in terms of capacity, they were trained. Several trainings are conducted. What may have been inadequate is the materials, the equipments."*

Other outcomes. The respondents also noted two other outcomes that may have occurred as a result of the trainings. First, the development partner reported improved attitudes of health workers toward COVID-19 patients: *"One, attitude. When you know that you can protect yourself, it influences how you look at a COVID patient, and how you respond."* Second, both respondents referenced broader community sensitization to COVID-19 prevention, including handwashing and social distancing.

Development of and capacity building on guidelines and protocols for operational management of COVID-19 patients in the private sector

This action was not one of the original action plans designed during the multi-sectoral workshop

in February 2020. In the months following the workshop, however, representatives who were engaged in other SMHS project actions recognized the need and opportunity to develop guidelines and protocols specifically for the private sector with regard to the treatment of COVID-19 patients. As such, this action was added to the project workplan as a new health-focused action.

This action was intended to achieve two key outputs (protocols for private sector management of COVID-19 patients developed and increasing the number of people participating in capacity building trainings on COVID-19 protocols). If successful, the protocols and capacity building would contribute to the outcome of private sector providers better adhering to standard operational protocols for management of COVID-19 patients.

Results. It is first important to note that only two people who were interviewed as part of this evaluation were directly involved in this action; as such, the results and perceptions of this action have only been validated by two informants (both from the public sector) and a limited number of documents that describe aspects of this action. Of the two people with whom we spoke about this action, only one was able to recall conducting outreach to the private sector to provide COVID-19 operating protocols[4]. This individual also noted that these protocols were not designed specifically for the private sector, stating: "*What we did was more for the county standard cutting across public and private sector. The effect there is that we still reached out to the private with the protocols. So not specifically for the private sector, but developed by public and disseminated to the private sector as well. And I mentioned, in our trainings, we made sure we reached out to the private sector*."

According to the key informant, both the development of protocols and capacity building activities were undertaken. Protocols were adapted from national level guidelines to address the needs of the county, and the respondent expressed that all subcounty managers identified people who should attend trainings on the protocols and included staff representatives from all facilities, including both public and private. Unfortunately, we were unable to acquire materials from these trainings to verify the inclusion of both public and private sector representatives. We do know from the private sector association list of requests made to the county that both "(s)ensitization on identification of suspected COVID-19 cases" and "(s)ensitization on transfer procedures as per the county response strategy" were requested. Conversely, the integrated COVID-19 budget for the county suggests that, as of July 2020, there was not funding or resources made available for capacity building for health workers. Overall, it is not possible to verify the degree to which this action took place. It is however worth noting that the public sector informant expressed that the private sector was not ultimately receiving COVID-19 cases when they were not prepared for these cases, stating: "*Largely, our private sector even did better than public in terms of infection prevention measures. They overdid in the sense that, when they didn't have PPE, they simply did not receive patients with COVID-19 related symptoms*."

Factors. Only one factor was discussed as playing a role in how this action transpired: financial resources. The public sector informant noted that there was a challenge related to cost of personal protective equipment that made it more challenging to provide all resources needed for private sector preparedness for COVID-19; however, this same respondent noted that this was *"a small gap*."

Other outcomes. The respondent did make note of two additional outcomes that s/he saw as resulting from this activity. First, the public sector informant observed that the protocols and capacity building helped to reassure private providers that may have been worried about opening during the pandemic, ultimately ensuring that facilities reopened: "*Right from the screening protocols, which enabled both public and private to the reopen their doors, like the strategy to isolate those who are considered high risk patients. Before that the public almost had*

[4] The second respondent expressed that they were not directly involved but could not say whether this action did or did not take place.

no service because service providers , public and private, feared COVID. We got to do this around late March and April, that's the effect that we saw a lot, access to more services because staff were more confident." Second, the respondent noted that the provision of guidelines and protocols helped providers understand how to operate when personal protective equipment supply was limited.

Capacity building of private providers on procurement of personal protective equipment, AND agreement via stakeholder forum on personal protective equipment procurement and disbursement process across public and private sectors

These related and complementary actions were not part of the original action plan developed during the February 2020 workshop. However, with the emergence of COVID-19, they were added as new health-focused actions as part of the project's pivot to address the pandemic. These actions were also in response to an acute shortage of personal protective equipment in Kenya felt across both sectors—but particularly among private providers—at the start of the pandemic.

These actions were intended to produce three outputs: (1) the number of private providers participating in capacity building activities for personal protective equipment procurement; (2) the creation of a desk within the stakeholder forum on personal protective equipment issues; and (3) a documented agreement on personal protective equipment disbursement. Ultimately, the actions were designed to result in outcomes including that private facilities would receive personal protective equipment disbursements from the public sector and private actors would be better equipped with personal protective equipment.

Results. A total of four respondents were interviewed about this action, including two public sector respondents and two private sector respondents. From the interviews and supplementary document review, it was clear that the private sector had submitted a list of COVID-19-related requests to the Kakamega County government including disbursements of personal protective equipment. At the national level, the Rural Private Hospitals Association of Kenya (RUPHA) had also released a memo outlining concerns around private sector preparedness for the pandemic and a number of requests for government support, including earmarked personal protective equipment donations for the private sector.

Despite this, it is evident that the actions around personal protective equipment procurement capacity building and agreements on personal protective equipment disbursement across sectors were not implemented. Both public sector respondents reported that each sector took their own responsibility for personal protective equipment procurement without collaboration, despite their recognition of private sector requests for support in this area. According to one public sector respondent, *"I know they didn't receive the support that they wanted from government…And rightly so because government was also overwhelmed. It's an area I feel we could have done better."*

Interestingly, one private sector respondent had a more positive perspective on these actions, stating that *"Yeah, there was some capacity building. I think the private sector was invited during the awareness creation on COVID. And so if that contributes to issues of PPE (*personal protective equipment)*, yes, in terms of awareness creation."* This respondent may have been referring to the capacity development trainings around COVID-19 protocols as beneficial relevant to the issue of personal protective equipment. The same respondent also reported that private actors contributed to the provision of personal protective equipment in the county, stating: *"I think I heard of some, I don't know whether you consider the NGOs* (non-governmental organizations) *part of the private sector…It is ongoing because there was a clear plan and a budget provision by the private sector, on what they could provide to the counties."* It is likely that the respondent was referring to support provided to the county by development partners, and documentation confirmed that the Kenya Medical Supplies Authority (KEMSA) had provided some personal protective equipment to the county. However, neither private

sector respondent reported that they nor any other private sector providers received any of these personal protective equipment disbursements.

Factors. The respondents clearly identified several factors that hindered the implementation of these actions. First, there were several environmental factors at play. One private respondent mentioned the lack of clear policy direction on what the county government should provide to the private sector. This lack of clear policy direction was compounded by bureaucratic roles in the county government, as described by one public sector respondent: *"In government, the procurement of PPE was a high level task, not even at my level. It was done between the county executive and procurement. But we had a small role in the CHMT in terms of distribution. We have a commodity manager who took charge of distributing what was delivered to us so we had distribution facilities. For procurement, it was a function within the executive."* On the private sector side, one private respondent mentioned the formation of the private sector association as a prerequisite to engaging with the county government on these actions and therefore a reason why the actions were not implemented. In addition, one public respondent also referenced factors including public sector resource constraints and the lack of logistical mechanisms for such procurement and disbursement arrangements across sectors.

Other outcomes. Since these actions were not implemented, it is unlikely that they would have produced any additional outcomes. However, one private sector respondent did mention changes to attitudes and interest in working together across sectors, as well as changes to the county's perspective that there is a need for them to support the private sector.

Sharing public sector schemes of service with private providers for use in developing their own

This action was one of the original action plans designed during the multi-sectoral workshop in February 2020. It specifically came out of discussions with a group that was focused on the shortage of human resources for health. One root cause to this challenge that the group identified was the lack of clear and standardized policies for health workers, including schemes of service and job descriptions. Based on this underlying problem, public and private sector representatives designed an action to help private sector provider standardize policies for human resources: sharing and then adapting schemes of service from the public sector.

While this action was not officially stopped or paused, partners agreed that this was generally deprioritized due to COVID-19. However, because no decision was made to stop the action, we continued to collect data on progress made on this action.

This action was intended to reach two key outputs (increase number of private facilities that receive the scheme of service and increase private representatives reporting that the scheme of service provided them with new knowledge). Ultimately, the outcome that this activity sought to achieve is that private providers have increased clarity about their job descriptions and pay which can become a benchmark that they can use in making decisions about their job and advocating for themselves.

Results. There was only one key informant who could speak to progress on this action, and we were unable to obtain any documentation to validate his/her responses. As such, it is important to note that the information presented on the sharing of the scheme of service represents one private sector provider's experience.

The respondent did confirm that the scheme of service from the public sector was shared virtually with the private sector via the Whatsapp forum developed for engagement between the sector representatives. Because this document was shared via the forum, there is good evidence that many private sector representatives who are on the forum now have access to this scheme of service.

Beyond this change, the respondent noted that the process of integrating and/or adapting the scheme for private providers is still ongoing, noting that other priorities (including finalizing the registration of the private sector association) need to occur first. However, the informant did note that simply sharing the scheme may be helping to shift mindsets: "*It has not been finalized, but I think by just sharing, it gave us a new understanding that this is what is done across, but then implementing it is where we are yet to do it*." This informant also noted that s/he saw this as a signal that the public sector now has more respect for private providers. Finally, and perhaps most concretely, the interviewee highlighted that the scheme of service itself may have provided important guidance to private sector actors regarding accessing important supplies and materials, stating: "*I think in the sharing of the scheme of service, it was that we now know where to get sanitizers. For example, in these times of COVID we now know where to get the right material when we want to use them, the masks and so forth. We changed on that because we have been sourcing these things alone, but this time, we can go through the county government and then maybe ask if they have any surpluses they can always share with the private sector. And if the private sector has also more, we can also subsidize the government so that we can also assist them with the same*."

MOU with county government and private sector in county for utilization of their services

This action was part of the original plan developed by public and private sector actors at the February 2020 workshop, recognizing the benefit of putting into place an MOU to formalize and guide the engagement between public and private sector actors. While the original action focused on general health system strengthening—including outcomes of ensuring adequate resources to support staff across both sectors and systems for sharing of services and skills—these outcomes shifted slightly to focus immediately on COVID-19 with the onset of the pandemic. The action thus sought to achieve two outputs, including (1) the MOU being signed, and (2) the number of facilities that reported using the MOU to share services and skills. In terms of outcomes, this action was intended to result in services and skills shared across the sectors when there is a gap or patient need not met by existing resources in their "home" facility. Ultimately, this action was intended to contribute to outcomes including adequate resources to support staff for COVID-19 response and systems for sharing services and skills across public and private facilities to fill gaps in service provision.

Results. Only three public sector respondents were interviewed about this action, limiting the amount and triangulation of the evidence collected. Of the three, one respondent said the action had not been implemented; the second did not remember or did not know; and the third described MOUs with other funders and partners outside the scope of this project. Given this, it is clear that this action was not successfully implemented and did not achieve its intended outputs and outcomes. This finding is further validated by reports from IHA. According to IHA, there were discussions with county government actors and an MOU was drafted, but was not signed by the county or by private sector actors.

Factors. When asked about the MOU, one of the three public sector respondents interviewed mentioned that IHA had been engaging on the MOU but that it had been slowed down by COVID-19. Besides this, however, all information on factors comes from IHA rather than the endline analysis itself.

According to IHA, a number of environmental factors may have been at play with regard to this action. First, on the side of the private sector, delays in the formation and registration of the private sector association—a prerequisite for the MOU, as the MOU's signatory would have been the private sector association leadership—caused delays in moving the MOU process forward. More significantly, however, were bureaucratic and political issues on the side of the public sector. The draft MOU must be reviewed and approved by a number of high-level stakeholders, including the Director of Medical Services, the county administrator, the county Minister of Health, and the county assembly. In addition to the prioritization of COVID-19 response by such stakeholders, IHA found that moving MOUs through this slow political process

is a challenge throughout the county and not unique to the SMHS project.

Improve communications between public and private sectors on COVID-19 response data, including feedback loops from DHIS to private sector

A modified version of this action (improving communications between the sectors on supervision outcomes and data) was part of the original plan developed as part of the February 2020 workshop with public and private sector representatives, facilitated by the SMHS project. This action came out of a small group discussion that focused on the problem of lack of standardized supervision in public and private facilities. In the months after the workshop as COVID-19 became a larger priority for county and private health providers, the issue of improved communication remained critical, but the action was adapted to prioritize data sharing for COVID-19 specifically.

This action sought to achieve two outputs: (1) increased frequency of communications on COVID-19 response data and (2) improved quality of communication on COVID-19 response data. These outputs were seen to contribute to two outcomes: (1) increased private sector receptivity to data feedback loops (and ultimately supervision) by the public sector and (2) improved experience and perception of communication by both sectors, initially on the issue of COVID-19 response.

Results. The interviewees who were engaged in this action (two from the public sector, one from the private sector) confirmed that there was regular sharing of COVID-19 information and data via both the stakeholder forum and the WhatsApp group, which we can confirm from our review of meeting minutes and WhatsApp communication. This communication evolved even from the start of the pandemic, with one public sector respondent noting: "*When we released situational report for Covid, we previously used to only share with public entities. As a result of that public private engagement and inter-sectoral collaboration with partners in Covid-19 management, it was agreed that it would be shared with private sector players*."

However, all interviewees also noted that, while this communication and sharing of data was regular at first, it seems to have slowed or stopped in recent months. There are several potential reasons for this reduction in communication, including two cited by respondents: a key officer involved in sharing data was quarantined due to COVID-19 and recently a health workers' strike. This reduction may also be a result of changes in perceived urgency related to the pandemic itself; however, we do not have confirmation that this is the reason.

There is more limited evidence that the action at this time has achieved either of the two outcomes described above. One respondent from the public sector highlighted some potential signals that this action has improved the perception and experience of interaction between the sectors, noting that they had not received any critical feedback from private sector representatives and that they are seeing the private sector more open to COVID-19 related supervision, saying: "… *we see a private sector willing to receive public health officers to inspect their facilities for Covid-19 regulation compliance. Government staff advising private facilities how they can be more compliant. No incident of refusal of entry or collaboration. I partly attribute it to this initiative*."

Factors. The primary factor cited as playing a role in the action's progress is outside forces that have disrupted communication. As noted earlier, several respondents discussed the health worker's strike and quarantine restrictions of public officers as reasons why this action was slowed in recent months. While these challenges were noted, one respondent also described the private sector as being "*hungry for information*," noting *"…when the situation report delayed, they would ask for it especially in the Whatsapp group. They are more alert and interested in Covid-19 trends. This was not previously the case*." This can be seen as some evidence of improved engagement by private sector actors and as one factor that may have helped this action progress.

Other outcomes. In addition to the outputs and outcomes described above, multiple respondents (representing both sectors) noted that the sharing of COVID-19 data helped to strengthen the two-way communication between the sectors, with one private sector representative saying: "*It heightened awareness on COVID situation and it included our voices*." In addition, one interviewee noted that this improved communication helped to increase reporting by facilities in general and allowed for better identification of problems where partners were needed to provide support.

Capacity building of private providers to engage in negotiation, accreditation, and contracting with insurers, including NHIF

This action was part of the original action plan developed by public and private sector actors during the February 2020 workshop, developed in response to identified challenges around reimbursement delays and funding flows to public and private health facilities. When originally developed, this action was focused on the creation of legal frameworks and regulations to allow providers to access funds from the county treasury. This was intended to improve the ability of facilities to negotiate for reimbursements, improving funding flows and ensuring that facilities would be reimbursed in a timely and accurate way.

After the workshop, however, the SMHS partners and involved actors recognized that the time and resource intensity of implementing this action would not be feasible for the project. As such, this action was first deprioritized and then adapted to focus on capacity building of providers to engage and contract with payers, including NHIF. This action was intended to achieve the following outputs: (1) increasing the number of people participating in different capacity building trainings, and (2) increased knowledge of contracting and negotiating with purchasers. Ultimately, this action was intended to contribute to the original outcomes, including (1) improve the ability of facilities to negotiate for reimbursements, (2) improved funding flows from the county to facilities, and (3) timely and accurate reimbursements for facilities.

Results. Only one public sector respondent was interviewed about this action, and as such there is limited evidence on whether and how this action took place. However, a review of relevant documents, including photographs and a participants list, showed that a meeting between the NHIF leadership, IHA, and CHMT representatives did occur in November 2020. From this meeting, IHA reported that the NHIF was eager to engage with public and private actors but had previously lacked the platform to do so. A virtual meeting was therefore planned between the NHIF and these actors to discuss how to engage moving forward.

The public sector respondent may have been a participant in that virtual meeting, according to the following quote: *"I was in the zoom meeting in December, and that one was actually the first step to bring on board all the other stakeholders. Because I can remember some of the partners like Pharmaccess was represented, there was somebody from, of course, the county and ourselves. It was a very introductory meeting, because each one of us was introducing what we do basically, so that we see areas where we can synergize."*

In terms of next steps, the responded shared that "*Nothing has happened. Actually it was a introductory meeting maybe a more very specific meeting was to follow in terms of the real things to be done. The real objectives."* It is therefore unclear whether there was any follow-up to this meeting. It should also be noted that the respondent referenced the participation of development partners but did not mention private sector providers.

Factors. While we were not able to obtain information on factors through the endline primary data collection, we have summarized in this section reflections from IHA on factors that may have hindered the success of this action. First, environmental and resourcing factors played a key role before the action was modified. While the original action was focused on the creation of

a legal framework, the SMHS partners recognized that changing laws at the county level was a very politically challenging activity that would require intensive advocacy and engagement of high-level stakeholders, including the county parliament. This level of advocacy would have required resourcing beyond the capacity of the SMHS project.

In addition, with the advent of COVID-19 in Kakamega County, the attention of key stakeholders was pulled away from broader topics such as health financing in order to prioritize immediate COVID-19 response. Without being able to meaningfully engage stakeholders around this topic, the creation of a new legal framework would not be possible.

Other Outcomes – Outcome Harvesting

While much of this analysis focused on outcomes identified as potential results of specific actions, SMHS participants were also asked about additional changes that they observed in relation to the engagements. These responses were analyzed to assess whether any common outcomes emerged from multiple sources.

Ultimately, two additional results were identified as potential outcomes from this analysis: (1) an increase in referrals between the public and private sector and (2) an increase in sharing or distribution of medical supplies (such as vaccines, family planning commodities, equipment and blood) between the public and private sectors. In the case of referrals, six interviewees noted that referrals had increased and that the referral system had improved as a result of the collaboration between sectors. In the case of supplies and commodities, three respondents noted this improvement, and this improvement was also noted by an additional partner during a meeting with project partners.

While these independent assessments of these potential outcomes is valuable, there was a need to triangulate data to better understand whether these outcomes are likely attributable in part to the SMHS project. To do so, the research team undertook additional interviews with partners to gather more data regarding the specific nature of these outcomes and to try to validate the connection with the project.

Referrals. In the case of referrals, the key informants were able to identify specific cases of people who they referred to and/or were referred by the other sector. These included:

- Clients with labor complications (including those needing blood transfusion), serious cases of ulceration of the abdomen, and serious malaria case (referred by a small private provider to public hospital); and,
- Clients for labor and delivery, injury requiring stitching, need for CT scan (referred by a public hospital to private providers with proper equipment and staff).

Respondents did note that these referrals represented an increase in cross-sectoral referrals in the past 12 months, providing evidence that this was a real result that occurred.

In addition to assessing whether the increase in referrals occurred, there is also a need to assess whether there is evidence that this happened as a results of SMHS activities. Based on interviews with respondents who have both referred patients and have patients referred to them, it does appear that there is some evidence that this change is in part associated with the SMHS activities. On the one hand, respondents did note that, in several cases, referrals had increased during a nurses' strike, when more cases needed to be referred to the private sector. However, interviews also revealed that the increase in referrals was perceived to be both higher and happening more smoothly than during previous strikes. Further, one private sector partner noted that he had never received a referral from the public sector before his involvement in the project and has now received at least three referrals during the strike. Respondents also noted that they perceive that this change was due to the SMHS project.

Supplies and commodities. In the case of supplies and commodities, we were able to identify evidence of an increase in supplies provided from the public to private sector, but not vice versa. Respondents from both sectors noted specific instances of supplies being provided from the public to the private sector, including:

- "nets, supply of mosquito nets, family planning commodities (injections, depo provera), … gloves and antiseptic like iodine" (responses from the private sector on what they have received)
- "penguin suckers for mucus extractors for use in high volume private maternities; Mother child booklets; Non pharms; Baby warmers; Incubators to faith based facilities" (responses from public sector on what they have provided)

Respondents both attributed this increase in sharing of supplies and commodities to the SMHS partnership; however, it is more challenging to validate this finding. At the least, there is evidence that some private providers who had not had the opportunity to work with the CHMT in the past were able to leverage the engagement that came about from the SMHS project to ensure that they received supplies and commodities when the public sector was sharing these.

Results – Helping and Hindering Factors

In addition to analyzing whether actions and subsequent outputs and outcomes occurred in association with the SMHS project, we also sought to better understand what partners experienced as helping or hindering the engagement. Above we shared feedback received regarding the role that factors played in specific actions; however informants were also asked about the broader role of factors from the Public Private Engagement Ecosystem (Figure 3) to provide more evidence regarding what may influence the effectiveness of approaches like these. Here, we present findings for nine types of factors (Environmental, Structural, Will to Engage, Trust, Mutual Understanding, Communication, Engagement Rationale, Technical and Managerial Capacities, and Accountability) as well as other factors that emerged in key informant interviews that do not fit into these categories.

The results presented below were gathered from endline interviews with key informants. Because of challenges due to COVID-19 as well as misalignment with baseline and endline informants, we are unable to conduct a direct comparison between anticipated factors from the baseline and realized factors from the endline. However, where possible, we include boxes to present interesting and relevant trends that emerged from baseline analysis, completed in early 2020.

Environmental Factors

Many SMHS participants cited factors related to the enabling and operating environment for PPE that both supported and hindered progress. On the positive side, one respondent from the public sector described **the organization of the private sector as helping the public sector know with whom to engage,** stating: "*But in essence, now whenever we engage we have space for the private sector representatives, it's known who they are. The fact that they have organised themselves as many as they are to a kind of organisation that has made that easy to achieve*." It is worth noting that this factor is also a direct outcome of the project, highlighting the interrelated nature of actions and factors, and specifically that the completion of one action can serve as a catalyst for other improvements.

In addition, several respondents (including those from both the public and private sector) highlighted that the **support of higher level political figures, including the county governor, made greater engagement possible.** One public sector respondent noted: "*The governor's administration was open to the whole idea of engaging the private sector it was an enabler. We didn't have a policy direction of these are competitors let's not engage. The environment was they are stakeholders, let's engage. The technical people were not hindered from engaging. We were encouraged and facilitated*." However, this perspective was not shared by everyone; a small subset of respondents noted that the private sector and development partners still face challenges in ensuring that their voices are heard by higher level political figures which can impede progress.

Other factors were cited as being challenges to the engagement, including two factors cited by multiple respondents. First, one public and one private representative both cited the challenges related to accreditation and reimbursement systems that make it difficult for the sectors to engage. While this factor initially appears to be more about the ability of individual facilities or providers to operate, both respondents noted that not being accredited also makes it more difficult for private providers to engage with the public sector on issues such as referrals.

Second, respondents (also representing both sectors) noted that, while political support is helpful, the bureaucratic procedures that dictate engagement between the sectors hindered the engagement. This bureaucracy was cited as a challenge both for the overall SMHS

engagement ("*Yes, particularly the public sector engagement there's a lot of bureaucracy sometimes when you are engaging with your local MOH* (Ministry of Health) *they have to listen to what the other voice from up there is saying, so if the other voice the attitude is not bought in you might find them delaying processes that even their representative thinks is a very good process. They may be waiting for a green light and if it not there then it will affect*."), as well as in regular operations between the sectors ("*For instance even if a service was available in a private facility the logistics for the patient using facilities next door would be difficult and it would be easier to refer this patient to a higher level facility that may be far away*.").

In addition, two public sector respondents noted that challenges at a higher level with the supply chain hindered the engagement, especially in light of the need for personal protective equipment during the COVID-19 pandemic.

Finally, several environmental factors were noted by one respondent as hurting the engagement, including: industrial strikes, power dynamics between private and development partners, and the lack of a PPE "culture."

Reflections from the baseline:

- One of the most cited expected challenges in the baseline interviews was bureaucracy from higher levels of government. Ultimately the endline in part validated this expectation, with several respondents from both sectors flagging the challenge of bureaucracy. However, it is also worth noting that many also highlighted higher-level political will and support as a helping factor.
- Issues with accreditation (specifically for NHIF) were also raised in the baseline, a factor that also emerged from two endline respondents.
- Some issues raised in the baseline (including the issues of political bureaucracy and obstacles to accreditation) may have also been in part addressed as outputs and outcomes of SMHS actions, as described in the previous results section.

Structural Factors

Structural factors were among the most frequently cited, with almost all respondents referencing factors related to resources, engagement model, third party support, or the formality of the engagement.

By far the most commonly referenced structural factor was resources. Respondents across sectors (including six public respondents, four private respondents, and one development partner) cited limited financial and human resources as a hindering factors that made the engagement process and the implementation of activities more challenging. Multiple respondents flagged constrained public financial resources as a key hindering factor across multiple actions that also prevented more meetings from taking place, as demonstrated through the following quote: *"With regard to financial context, within the government side we are already constrained in terms of resources. Some of the things that the private sector requested included financial input that [couldn't] be met due to existing constraints."* In terms of the engagement process across sectors, lack of government funding for logistical support such as airtime and conference packages was also seen as a hindrance. Some respondents mentioned bureaucracy and protocols that must be followed for the county to receive funding as a cause of this problem.

While constrained government resources were most frequently cited, insufficient resourcing by both partners and the private sector also emerged as factors. Two public respondents highlighted lack of funding support for meetings from SMHS and IHA[5] as an issue that affected the morale of some public actors and created strain between the project and the county

[5] Due to funding constraints, SMHS was unable to provide direct funding support for meeting costs.

government. On the side of the private sector, two private respondents referenced general resource constraints across the private sector, including for logistics such as transport for meetings. Another respondent highlighted issues of joint resourcing: *"Budgets for forums was inadequate and the government players did not incorporate the stakeholder forums into the county budgets leading to reluctance by the private sector to support the forums."*

It is worthwhile to note that despite these resourcing challenges, a few respondents also reported that joint resourcing through engagement and the stakeholder forum was helpful, especially in terms of human resources and commodities. This may have been especially true for Kakamega County development partners, one of whom shared that the stakeholder forum allowed partners to better coordinate their activities to support the needs of the county: *"We were able to consolidate resources, to ensure activities are done. And we are effectively supporting the county."*

Another hindering factor raised by several respondents was a lack of pre-existing policies and structures for PPE in Kakamega County. While one public respondent felt that a pre-existing policy did exist and had been revived by the engagement, others (including two public and one private respondent) reported that the lack of any pre-existing policy or structure slowed the engagement down. As stated by one public respondent, *"I think the weak pre-existing structures for engagement slowed down the process, because it was like building a new house."* Two respondents from the public and private sectors also mentioned the slow progress on signing an MOU for the engagement as a hindrance.

However, respondents across sectors (including two public respondents, one private respondent, and two development partners) also reported that formalization of the engagement structure via the stakeholder forum helped the engagement. Respondents mentioned the development of terms of reference for the stakeholder forum as helpful for guiding the engagement, including who was engaged and frequency of meetings. The formation of committees or technical working groups was also cited as helpful.

Regarding the engagement model, third party support also came up as a factor that helped to further the engagement. Respondents across sectors (including two public respondents, two private respondents, and one development partner) shared reflections on the support provided by IHA that helped to rally both sectors and bring them together in the engagement, as well as the advice IHA provided to formalize the engagement process: "*A vote of thanks to the IHA team, we have been working closely with Dr Marani and we have managed to achieve something that nobody has looked into before in bringing private stakeholder to the table in regards to health related issues."* Some respondents also cited specific instances of support, such as IHA's help in acquiring the services of a lawyer for registration of the private sector association.

While third party support from IHA was a helping factor, it was not without challenges. In addition to the financial resourcing constraints mentioned above, two respondents from the public and private sectors flagged challenges related to IHA's lack of a local office in Kakamega County, which they perceived to negatively impact coordination and communication.

Reflections from the baseline:

- As in the endline, challenges with resources came up as the most frequently cited structural factor that baseline respondents anticipated would hinder the engagement. The baseline also reflected the same diversity of resource challenges that came up in the endline.
- However, other anticipated hindering factors from the baseline were either less prominent or were in part addressed as part of the program, according to the endline. First, while the issue of lack of policies and structures did come up as a challenge both before and after the program, several actions addressed some of the issues,

such as private sector organization and stakeholder forums, which ultimately made this less prominent in the endline. Second, the baseline highlighted many misconceptions between the sectors about resource availability, an issue that was cited much less frequently in the endline.

Will to Engage

Reflections on will to engage as a factor were overwhelmingly positive, with almost all respondents reporting that goodwill and will to engage from either or both sectors contributed to the success of the engagement. This is demonstrated through the following quote from a public sector respondent: *"The private sector was very willing to engage as well as public sector. So everyone saw value to engage with the other. So it was like a pre-existing hunger, it didn't require so much energy to tell either party to engage."* It should be noted that two respondents (one public and one development partner) did mention challenges with public sector will to engage, including a public respondent who felt that government will to engage could still be improved and a development partner who referenced senior public officials who require per diems or other incentives to participate in engagement activities such as meetings.

Similar to several other factors, findings on will to engage are nuanced in that goodwill positively contributed to the engagement, and the engagement itself may have helped to improve goodwill and willingness between sector partners. On the side of the public sector, three public sector respondents shared that the engagement helped government actors to change their perspective on the value of engaging with the private sector. These respondents mentioned "bad blood" between the sectors in the past and shared that while at first PPE may have been a novel idea, through this engagement they have become more receptive to engaging with private sector actors.

While there were fewer themes specific to private sector will to engage—potentially because there were fewer private sector respondents in our sample—a few themes did emerge, again related to improvements to will to engage that occurred as a result of the project. Two respondents in the public and private sectors mentioned the formation of the private sector association as a key mechanism enabling private actors to engage with the county government. One public sector respondent shared their perception that the will of the private sector to engage had increased due to COVID-19, stating that *"We've seen a private sector that is more hungry for information, when the situation report delayed, they would ask for it especially in the Whatsapp group. They are more alert and interested in Covid-19 trends. This was not previously the case."* Finally, two public sector respondents shared that since the project began, the private sector is now more willing to receive and participate in supportive supervision from the public sector, which was previously not the case.

Reflections from baseline:

- One striking difference between the baseline and endline was the perception that respondents had of the will of other sector actors to engage, with baseline perceptions being mostly negative and endline being mostly positive. While we cannot directly compare these findings because only a small portion of the respondent pool was the same for the baseline and endline, this still suggest that there was an increased will to engage – and perception of other sector will to engage – that developed over the course of the project.

Trust

While trust can be viewed as a factor that potentially played a role in how actions and the engagement as a whole progressed or lagged, **many participants actually noted that**

increased trust was an outcome of the engagement itself. These responses, which came from both public sector and development partners, noted the importance of having opportunities to sit together, have open and transparent discussions, and increase confidence in the partners that are working together. This mindset change can be seen especially in one quote from the public sector: "*It is after this meeting, that we sat together, we were able to talk and then now they are seeing us like we are brothers and sisters, we can be able to share many things, not the way they were seeing us like visitors*."

Observing improvement in trust as a result may have also reflected the fact that, according to several respondents, trust between the sectors in the past was significantly lacking. In fact, one public sector interviewee stated: "*There was mistrust between the partners and poor leadership-not receptive, not willing to meet for policy issues*."

The primary and preliminary component of trust is a willingness to meet to try to resolve these past issues, which six respondents explicitly stated was a helping factor in this engagement. From the private sector, one respondent noted: "*I think the confidence and goodwill promoted, then engagement. It allowed the conversation. Yeah*." One development partner went further, noting a specific outcome of the improved trust: "*After we built confidence, and that trust, even between partners, it became easier to even like be open on our activities and even leverage on each other's capacities, because different partners are strong in different areas*."

While the majority of respondents provided feedback on trust being a positive factor and/or outcome in this engagement (including one public sector respondent noting that they themselves were seen as trusted by others), there were a limited number of responses (from three interviewees) suggesting that there may be lingering feelings of mistrust. For example, one respondent from the public sector noted: "*However some few partners were active to implement the workplan while some other gave ideas but they went quiet. They may have expected some windfall from national government funds. Others came in to ask us to finance them to carry out activities.*" Finally, one partner highlighted a warning about the potential for other factors (like bureaucracy) to erode emerging trust.

Reflections from the baseline:

- While baseline respondents were not asked directly about trust, it is still important to note that this did not come up explicitly as a factor in interviews conducted at the start of the program[6]. However, responses related to misconceptions across the sectors (especially from the public sector in reference to the private sector) suggest that there were some feelings of mistrust at the start of the project. As such, the largely positive responses from the endline may provide some evidence of improved trust during the 12 months of the project.

Mutual Understanding

Responses on mutual understanding as a helping or hindering factor were mixed. Respondents across sectors (including three public respondents, one private respondent, and two development partners) shared that interactions between sector actors, including through the stakeholder forum in the context of COVID-19, helped to improve mutual understanding, which in turn helped the engagement. These improvements to mutual understanding included clarifications of roles, especially in the context of COVID-19, as well as improving positive perceptions across sectors as demonstrated through the following quote from a private sector

[6] The interview protocol was in part designed based on the current version of the factor ecosystem at the time of the interviews. Based on continued review of the evidence and experiences from baseline interviews, we adapted the ecosystem to later include trust and mutual understanding. However, because these factors were introduced later, they were not included explicitly in the baseline interview protocol.

respondent: *"I think there is some awareness created, there should be increased engagement for better and probably somehow towards a comprehensive understanding...I think it helped in terms of improving positive perceptions that we are all serving the same interest and that synergies can be created through working together."* Work planning through the stakeholder forum helped actors across sectors—including development partners—understand one another's plans, resources, and gaps.

However, mutual understanding in the engagement was not without challenges. Related to issues of resource constraints, three public sector respondents shared that misaligned understanding of the government's role and resources as a key issue. They shared that while they saw their role as focused on regulation and standards, private sector actors came with requests for support that included government financing and provision of supplies. These expectations introduced strain and friction to the relationship when they were not met and gave some government actors the perception that the private sector was seeking to benefit from the government rather than pursue a mutually beneficial relationship. This misalignment in understanding was corroborated by one private sector respondent, who reported that it was not clear what the county was supposed to provide to the private health sector.

Overall, respondents appeared to recognize that improvements in mutual understanding had benefitted the engagement but felt that they were still in the early stages of fully understanding one other's roles, and more work remains to be done in this area.

Reflections from the baseline:

- As with trust, baseline interviewees were not asked directly about mutual understanding. However, many respondents raised points about the capacities of the other sector in the baseline interviews, suggesting significant misunderstandings about roles. There is limited evidence from the interviews to suggest that some of these misunderstandings may have been resolved; however, the endline responses remain mixed.

Communications Factors

When asked about the role of communications in the engagement, respondents were decidedly mixed in terms of whether this was a helping or hindering factor. Almost all of the seventeen respondents commented on the role of communication, with approximately half of the responses highlighting appreciation for the frequency, openness, and two-way flow of communications and half noting the inconsistency of communications broadly and meetings specifically.

Diving deeper into responses, two respondents (both public sector) noted the challenge related to not being able to meet in person due to COVID-19. However, seven interviewees praised the resilience of the partners in adapting to these challenges and finding creative means to interact when in-person discussions were not possible, including: WhatsApp forums, Zoom and Skype.

Beyond communications mechanisms, some participants noted challenges with the other sector that made communication more difficult, including: bureaucracy and formality of scheduling meetings with the government (response from development partner), lack of clarity on who key private sector contacts are (response from public sector), and perception that the public sector was not proactive in how they were communicating and sharing with the private sector (response from the private sector).

Despite these challenges, one public sector respondent noted that s/he perceived improved communications with the private sector as an actual outcome of the project, and one development partner noted that the structure of communications between technical working groups in the stakeholder forum improved how they were able to communicate with relevant partners.

Reflections from the baseline:

- Baseline respondents noted both the need for and importance of better communication to make the engagement effective; further, all respondents agreed that there were not good communications mechanisms in place between the sectors before the project started. As such, the positive responses regarding communications from half of endline interviewees suggest some improvement, at least in the early stages of the project.

Engagement rationale

For the purposes of this project, we define "engagement rationale" as the basis and motivation for the engagement (related to a validated health system gap), including mutual benefit through pursuit of common goals and the underlying motives of each sector partner. Having a positive engagement rationale can take two major forms: (1) partners from different sectors have a common or shared goal for the engagement or (2) partners have different but complementary goals such that both see value in working together in pursuit of their individual goals.

Responses related to both common goals and complementary goals emerged in the interviews with SMHS partners, with the majority of respondents agreeing that engagement rationale improved the project as a whole. Starting with common goals, eleven respondents (representing all sectors) stated that they believed that all partners had a common goal for this engagement which helped to strengthen the work. These stated goals varied slightly, focusing on improving health services, lowering maternal mortality, and combatting covid. However, while some of these same respondents acknowledged that partners have multiple goals and some of these may differ, there was broad consensus that working toward similar goals helped the engagement.

In addition, seven respondents (representing all sectors) noted that they saw real value in working with partners from the other sector due to the ability to help each other in pursuit of complementary goals or "haves and needs." Partners noted issues such as working together to ensure that they were not duplicating efforts (i.e. all challenges and needs covered by different partners) and in the sharing of resources across the sectors. While most of these goals were secondary in nature (focusing on means to get to shared outcomes), they were still cited as factors that helped ensure an effective engagement.

While many of the responses related to engagement rationale were positive, there were a limited number of respondents (three) who noted some questioning of the motivation of the other sector. Related to trust, this factor emerged from public and development sector respondents, echoing a common belief that many private sector actors were in fact engaged as a means of making profit and acquiring resources (such as personal protective equipment) from partners. While these perspectives are important to acknowledge, it is also worth noting that all three of the participants who cited these beliefs also stated that they largely believed that all partners had a common goal.

Reflections from the baseline:

- There were very similar trends that emerged from the baseline and endline regarding engagement rationale, with largely positive responses regarding both a shared vision or common goal and opportunities for complementary "haves and needs." It is worth noting that baseline interviews were conducted the week after the initial co-creation workshop between partners; as such, the positive responses in the baseline may reflect optimism immediately following a workshop that sought to help partners develop a shared vision.

Technical & Managerial Capacities

Technical and managerial capacities were frequently cited across respondents as factors that both helped and hindered the engagement. On the positive side, several respondents across sectors (including three public, one private, and two development partners) felt that the CHMT had the right capacities to effectively manage the engagement. While only one private sector respondent spoke to the capacities of the CHMT, that person stated that *"I must say I was very impressed by the technical and managerial capacities of the of the MOH team."*

Despite these positive perceptions of public sector technical and managerial capacities, several respondents across sectors (including two public, two private, and one development partner) also flagged challenges with inconsistencies in public sector coordination, leadership transitions, and bureaucracy that slowed the engagement down. The same private sector respondent who spoke positively of the CHMT's capacities tempered their remarks with the following: *"In terms of MOH, I think there are structures that hinder them from doing many things, the bureaucracies."* The other private sector respondent mentioned that the public sector took a long time to move the work forward. Public sector respondents appeared to concur with these sentiments, sharing that *"when it comes to implementation, some logistical challenges may not allow us to move at the same pace we'd like to achieve, there's bureaucracy in both sectors."* Some respondents, particularly the development partners, also referenced the leadership transitions experienced by Kakamega County government during project implementation as a challenge.

Regarding the private sector, respondents across sectors (including two public, two private, and one development partner) reported heterogenous capacities across private sector actors in the county that both helped and hindered the engagement. For example, a public sector respondent stated that *"We were dealing with experienced players in the private sector who have been there for some time and they didn't have problems synchronizing with us."* However, that same respondent also directly referenced the challenge of heterogeneity across the private sector, saying that *"Various organisations are at different levels. Some have technical officers who resonate with government officers. Others were thin such that the officer lacked capacity to comprehend technical issues. Contribution to discussion by such officers disjointed."* That respondent also referenced frequent private sector staff turnover and lack of shared contact information as hindrances to effective communication. Other respondents flagged specific challenges related to private sector capacities, including limited financial capacity and poor data collection and reporting.

In addition to these factors that helped or hindered the outcomes of the engagement, respondents also shared that improvements to these factors were actual outcomes of the engagement itself. In relation to challenges with private sector capacities, three public sector respondents referenced capacity development activities that the public sector is undertaking with the private sector. While some of these activities, such as trainings and supportive supervision, may have taken place prior to the SMHS engagement, one respondent mentioned that the public sector is now seconding staff to some private hospitals to help with technical expertise. Another stated that *"[the engagement] did affect positively because when we involved [private actors] in our in Annual Workplan and our quarterly review meetings, after sharing how the services are in their facilities those private players there was change in terms of positivity, best practices were adopted for example in documentation, which had been a challenge."*

Similarly, respondents across sectors (including four public, one private, and one development partner) shared that coming together helped to improve joint planning and leadership across sectors. Another private sector respondent reported that the formation of the private sector association helped to improve private sector capacity and ability to engage with the county government.

Reflections from the baseline:

- The majority of responses related to capacities of the sectors as well as joint planning and leadership in the baseline interviews were negative. Specifically, many public sector respondents highlighted concerns regarding private sector capacity, with some concerns about private sector capacity (staff bandwidth and capacity for data sharing and reporting) being shared by both sectors. Further there was overwhelming agreement by both sectors that the private sector was often excluded from county-wide health planning. In this regard, while some endline respondents highlighted limited capacities and joint leadership as hindering the engagement, the positive responses still represent a more optimistic picture than the baseline presented.

Accountability

Accountability was the most infrequently mentioned factor in the analysis, with only 12 relevant quotes emerging across all interviews. The strongest theme related to accountability emerged only from development partner respondents, two of whom shared that the stakeholder forum had helped to clarify roles and responsibilities across partners and hold partners accountable for work they committed to in joint planning processes, as they had to report back on what they had done to the forum.

One public sector respondent also mentioned that for planning related to COVID-19 response, not all partners were willing to share their budgets and therefore could not be held to account, which was a challenge. Otherwise, while respondents appeared to agree that accountability is important to partnerships, responses were general or not specific to the SMHS project.

Reflections from the baseline:

- As in the endline, accountability was not a factor that emerged in baseline interviews.

Other factors

While we began this analysis with a framework of factors derived from review of the evidence and experience working in mixed health systems, we did observe a limited number of comments regarding factors that were not otherwise included in the ecosystem that we sought to test through this primary case. Of the 54 quotes that noted the role of a factor not covered by the ecosystem, the vast majority (50) covered a single topic: COVID-19. When we first developed this ecosystem, it was several months before the COVID-19 virus was acknowledged to be a pandemic, and as such we could not have recognized that this would be such a critical factor in the progress of the SMHS project. With that said, the diversity of responses related to the role of COVID-19 is noteworthy.

The majority of respondents highlighted the overwhelming challenge that the pandemic created in relation to pursuing activities and actions originally designed as part of the projects. These obstacles included delayed or cancelled in-person meetings, challenges to communication, stopping of supervision, and several other specific roadblocks. It was further noted by two respondents that COVID-19 directly affected partners, with key officers falling ill and/or quarantined at important moments in the project.

Interestingly, the reprioritization of county health system needs also emerged as an important factor, with some citing this as a positive and other as a negative. On the hindrance side, five participants (all public and development sector) noted that the pandemic left partners needing to focus on other activities. One development partner noted: "*I think the COVID-19 put everything in disarray . As we started to respond, we had more frequent engagements, but as time went by, the engagements became few because of competing tasks*." Further, one public sector

participant went so far as to say: "*COVID is number one, because COVID reduced most of our efforts to what must be done, you know, it was more of a survival mode- what must you do to cross the bridge. And also the things we cannot do for us to stop the spread, so I'm almost thinking if we had the open space most of the envisaged milestones would have been implemented*."

However, five respondents (also public and development sector, with some included in the previous responses) also noted that the pandemic may have helped the engagement by helping partners see the need for collaboration, especially in times of emergency. One public sector partner stated: "*COVID times helped us know we need each other. So we understand government has its muscle role and private sector its support role*." Another public sector respondent provided even more specific feedback: "*In the Covid pandemic we realized that we need the collaboration of the private sector. For example, critical care services, private facilities referred to Level 5 for ICU services. Only facility with ICU facilities. Need for engagement so that when they refer there's a smooth transfer. I am more convinced that there's need for us to stimulate the private sector to improve their facilities such as Critical care facilities*."

In addition to COVID-19, three other factors were cited (each by one person) as playing a role in the progress made during the engagement: the timeline for the project being too short (hindering), challenges in power dynamics across the partner (hindering), and a good road network (helping).

Discussion

Engagement actions were more successful relative to health actions. An interesting finding revealed by the process evaluation methodology is that the engagement actions were relatively more successful in achieving their intended outputs and outcomes than health actions. Public and private stakeholders made significant progress on critical actions that better enabled sector actors to engage with one another, including the formation of the private sector association and setting up the stakeholder forum; notable progress was also made on engagement actions including increasing private sector representation in county work planning and developing the capacity of the CMHT to manage private sector engagement. In contrast, while some progress was made on several health actions, such as sharing of schemes of service and COVID-19 protocols across sectors, others saw little or no progress or there was a lack of clarity around their results.

There are several potential reasons behind the differential results between engagement and health actions. First is the hypothesis that the engagement actions were more foundational to collaboration between the sectors. Structures including the private sector association and the stakeholder forum were essential to enable successful interactions between sector actors; given that the engagement and health actions were implemented within the same timeframe, it is possible that the health actions were not able to make as much concurrent progress while the foundational engagement actions were still in process.

In addition, it is possible that the health actions progressed less relative to the engagement actions due to the nature of the actions themselves. It is likely that the health actions were stymied due to the onset of the COVID-19 pandemic, given that many health actions necessarily shifted focus to the immediate needs surrounding the COVID-19 response in Kakamega County. Further, we may have seen less progress on the health actions since it may take a longer time period to see their full impact—especially for actions designed to achieve outcomes such as better adherence to protocols and changes to policies and regulations. Along a similar line, it is more challenging to qualitatively collect meaningful data on the outputs and outcomes of the health actions, which ideally would involve facility-level data. This limitation may explain the lack of clarity in the process evaluation for several health actions.

Interestingly, however, it appears possible that the foundational engagement actions themselves may have helped to enable some of the progress on the health actions. For example, one health action—public sector provision of supportive supervision to the private sector—was dropped from the analysis due to lack of progress after the onset of COVID-19. However, it was raised several times in endline interviews that the public sector now perceives the private sector to be more receptive to supervision by the public sector, which was one of the intended outcomes of the dropped action. This implies that even if partners did not make direct and intentional progress on this health action, increased engagement and collaboration through the foundational engagement actions may have helped to achieve a desired result.

External shocks as challenges versus windows of opportunity. When launching the PPE in Kakamega County, neither the SMHS partners nor the public and private sector actors knew that the world would significantly change just days after the co-creation workshop. In the early months of the engagement, the partners were forced to pivot and adapt to address the increasing crisis of COVID-19. While the majority of involved actors described COVID-19 as bringing a set of significant challenges—such as competing and changed priorities and the struggles of virtual communication and lockdown restrictions—the analysis also found nuance in the implications of COVID-19 and other shocks for PPE in the county.

COVID-19 and other external shocks may have brought windows of opportunity for PPE in addition to challenges, and there is some evidence that the pandemic may have helped to move

the engagement along despite those obstacles. For example, the evaluation of the health action focused on improving communications between public and private sector actors on supervision outcomes and data found that COVID-19 may have brought an increased sense of urgency to communication between the sectors, especially from private sector actors hungry for more information and guidance from public officials. Notably, regular communication between the sectors tapered off near the end of the project, possibly because the pressing need related to COVID-19 had been ameliorated.

Similar nuance can be observed around health workers' strike that occurred during the implementation period. While the strike was largely perceived to be a challenge, there is also evidence that it created opportunities for increased sharing of services and referrals between the sectors, as the public sector increasingly referred patients to private sector providers when unable to provide care due to the industrial action. While challenging, these external shocks may have motivated sector actors to come together and collaborate in order to address them—and further, one could hypothesize a virtuous cycle in which improved engagement between sector actors will better prepare them to adapt and respond to shocks in the future.

Movement on unanticipated outcomes. Further validating the hypothesis that external shocks can bring windows of opportunity for engagement is the fact that we observed outcomes that were different and arguably bigger than what was anticipated at the beginning of the project. Most notable was the increase in referrals and improvement to the referral system between the public and private sectors, where there is evidence that the improvement was associated with both the health workers' strike and the SMHS project itself. The potential outcome of increased commodity sharing between sectors is also interesting, though there is less evidence that this was directly associated with the SMHS project. Despite this, it appears possible that improvements to PPE—particularly through the engagement actions and their associated structures, platforms, and capacity development—helped to enable both sectors to organically identify and act on areas for collaboration, including in the face of shocks.

Baseline factors may have been endline outcomes. Turning to factor results, one striking finding that emerges is that many of the factors that respondents anticipated would be challenges at the start of the program were not prominent or did not appear at all during endline interviews. There are several potential reasons for this difference between baseline and endline; however, one probable reason is that many of the factors that respondents initially predicted to hinder the engagement were issues that the actions actually sought to directly address. Two examples of this trend are structural factors and will to engage. For the former, the baseline included several informants who expected the lack of policies and structures for engagement to be a challenge for the SMHS project; however, many of the engagement actions in particular were undertaken to develop and initiate structures such as the private sector association and the stakeholder forum, making this a success as opposed to the hindering factor that it could have been. On will to engage, while no action explicitly was designed to address will to engage, the fact that this was noted as a likely hindering factor at the start of the project, only to become a largely positive factor at the endline, suggests that improved will to engage was an outcome that improved during this project.

This observation is not completely surprising, as one hypothesis of the SMHS project was that an approach that seeks to improve engagement between the sectors could improve the effectiveness of the PPE in contributing to other outcomes. We designed the approach with this in mind, and thus many engagement factors in particular that had historically been viewed by partners as roadblocks were in fact preliminary targets for the PPE. With that said, actually observing these changes matters because it suggests that factors are not only dynamic, but they can also in many cases be directly acted upon by PPE stakeholders. Engagements should take opportunities to assess current perceptions and experiences with different factors at points throughout a PPE timeline. Those factors that are assessed as being hindering or potentially problematic do not need to be accepted as static challenges; instead, partners can work to directly address these challenges, creating a strong ecosystem for this work moving forward.

Importance of Third Party Support. While key informant interviews did not explicitly ask for feedback on the role of IHA's support in the effectiveness of the engagement, unprompted responses make it clear that the continued capacity building, facilitation, and technical support provided by IHA was perceived as critical to this work. These responses ranged from partners citing the importance of IHA in continuing to bring together and facilitate dialogue between partners who had previously not engaged to specific instances of support for actions such as working with the lawyer to facilitate the registration of the private sector association.

While there were also a smaller set of comments highlighting challenges with IHA's engagement, these overwhelmingly linked to two issues outside of the control of the project: (1) the fact that IHA was not based in Kakamega and thus was not always in the county and (2) limits on financial resources for some components of the engagement (such as some restrictions on funding of meetings). These challenges are important to flag, but they do not speak to the ineffectiveness of third-party support from IHA; instead they highlight the need for additional resources (including time, technical support, and in some cases financial) to create the foundation for new PPEs.

Together, this input (both supportive and constructive) points to the immense value for flexible and intensive third party facilitation and support to foster new engagements. The role of independent broker is one that does not exist in many PPEs, but it is one that is worthy of further piloting and study, given the promise that emerged from the SMHS engagement.

The Other Third Party. While much of the analysis and results focuses on two sectors (public and private), it became clear early in the project that a third sector was critical in how this engagement progressed: development partners. A small number of development partner stakeholders were invited to and joined the co-creation workshop in February 2020, and these and other actors were actively involved in several of the actions, including the stakeholder forum. For many reasons, including some limitations in the data collection strategy, it is difficult to say whether the engagement of development partners ultimately supported all of the project goals.

On the one hand, development partners may have helped to bring public sector actors to the table at the start of the project; members of the CHMT noted that they have had strong working relationships with development partners, which may have made them more comfortable to engage with the project. Development partners may have also lent credibility to non-public actors as a whole; government stakeholders noted that they saw development partners as high capacity and thus were happy to work with them, which may have helped their impression of smaller providers as well.

With that said, interviews with government officials in particular made it clear that some positive feedback on the private sector was referencing development partners rather than smaller private providers. As such, while we know that public respondents point to improved engagement and perception of private providers, we also know that in at least a few cases this extends to, and may largely reflect, perspectives about development partners. It is also noteworthy that development partners have played an active role in the stakeholder forum, one of the key avenues for direct and concrete engagement between the sectors. It is difficult to know whether development partner participation augmented that of private provider representatives, or if it may have substituted in some cases.

Progress on a long journey. A final reflection that arose many times in the interviews and review of documents was that there was very clear and impressive progress toward engagement and health outcomes, as well as improvements in factors, even in cases in which the finish line is still in the distance. The SMHS PPE started from a very small foundation; in 2019, representatives from both sectors expressed an interest in better engaging with the other sector while acknowledging that this was something that had not been done in the county before and that there would be myriad obstacles. From the time of the co-creation workshop when

sector representatives were first brought together, stakeholders had 12 months to pursue an ambitious agenda that they set out to build this engagement and improve maternal health in Kakamega. They did have support from IHA and the project during that time; however, they also were immediately contending with an unprecedented public health event , COVID-19. So what can we make of the fact that, for many outcomes and actions, there was progress if not completion?

One view might be that 12 months is an incredibly short time period to make substantive change on issues like trust and will to engage in a place where sectors were just beginning the process of substantive engagement. When changes such as the pandemic and political changes are added, it raises questions of whether the plan that partners sought to pursue was realistic for the time allotted. There are some signals that a limited number of milestones, such as regular data sharing between the sectors, may have started to wane by the end of the project. This may be a temporary change (partners noted issues such as quarantine and illness among health officers that delayed communications and that hopefully is time-limited). But these observations do present a real question – how much time is needed to create a foundation for engagement when one did not previously exist? While we cannot answer this question, it does seem reasonable that more time with technical support and facilitation would help ensure that the journey – and the momentum of partners – continues to build.

A more positive view – one that is not contradictory to the point made above – is that there are some actions, factors, and relationships between partners that are likely to be longer-lasting, even after a relatively short period of support. We see clear signs of this, even after data collection ended and we began the process of closing the project. After the project close-out meeting, the private sector association was holding a meeting that was interrupted by a member of the CMHT that was the newly appointed (and inaugural) private sector liaison for the county. She had been approached by a donor that sought to provide support for community health workers in the county, and she immediately identified that the private sector association would be the right partner and beneficiary for this support. At a national level, a partner that was engaged as a representative of a national private health providers association noted that, after observing the work in Kakamega, the model of creating county-level private sector associations is one that her organization had plans to expand across the country. These changes, the foundation of which was set in a short 12-month period, are major milestones that would not otherwise have been met. They demonstrate the significant and far-reaching effect that approaches like SMHS can have in pursuing more effective mixed health systems – and the promise of similar approaches outside of this pilot case.

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RESULTS FOR
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