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THE INFLUENCE OF CROSS-CULTURAL COMMUNICATION ON THE STRATEGIC GROWTH OF FAITH-BASED MISSION HOSPITALS IN KIAMBU AND NAIROBI COUNTIES

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ABSTRACT

Purpose of Study: The overall goal of this study was to assess the role of cultural diversity training on the strategic growth of faith-based mission hospitals in Kiambu and Nairobi Counties. Understanding the effects of training as a component of cultural diversity management on strategic growth goals is vital because these hospitals manage the intersection of the varied cultural backgrounds of their stakeholders, patients, and staffs.

Problem Statement: Faith-based mission hospitals operate in a difficult environment, balancing faith-based values with financial sustainability and competitive staff compensation. In addition to engaging in Corporate Social Responsibility (CSR) and adopting strategic frameworks for growth, these hospitals face the challenge of integrating cultural diversity into their operations.

Methodology: The study adopted a descriptive research design to investigate how cultural diversity training affects the growth of faith-based mission hospitals. It was anchored on diversity management paradigms, Hofstede's Cultural Dimensions Theory and the Resource Based Theory. The target population was 454 diverse employees from 17 hospitals in the study counties with a sample size of 265 individuals selected using stratified and random sampling. A structured questionnaire was used to collect data and was analyzed using the Statistical Package for Social Sciences (SPSS) for both descriptive (percentages, means and standard deviations) and inferential analysis (Correlation and regression)

Result: The Pearson Correlation coefficient revealed a very strong positive relationship between diversity training and the strategic growth of faith-based hospitals. Suggesting that investing in such initiatives can lead to improved patient care, employee satisfaction, and overall organizational success.

Conclusion: The study concludes that faith-based mission hospitals should prioritize diversity training as a key strategy for growth due to its strong positive impact. This study could benefit

hospital administrators and managers in faith-based mission hospitals for it has provided insights that would enable them enhance cultural diversity in their institutions.

Recommendation: Faith-based mission hospital's leadership should incorporate comprehensive cultural competence modules into training programs for staff.

Keywords: *Cultural Diversity Training, Strategic Growth, Faith Based Mission Hospitals*

INTRODUCTION

The strategic growth of Faith-Based Mission Hospitals (FBMHs) plays a critical role in improving community health and ensuring sustainable healthcare delivery, particularly in underserved regions. FBMHs are dedicated to holistic care, addressing not only the physical but also the emotional, mental, and spiritual needs of patients. They often form partnerships with local communities, religious institutions, and governments to expand their reach and impact (Olivier & Wodon, 2014). Training and capacity-building efforts are also prioritized to strengthen clinical services and empower local healthcare providers (Kengia & Nelson, 2020).

In various regions, FBMHs employ unique strategies to extend their influence. For example, in the U.S., they expand their services through novel medical practices, support services, and partnerships with other organizations (Norris, 2021). In Europe and Asia, many FBMHs participate in international outreach efforts, offering humanitarian aid and collaborating with global partners (Winiger & Peng-Keller, 2021). In Africa, FBMHs rely heavily on donor funding and cultural diversity, which helps them offer patient-centered care that respects local traditions and beliefs (Fubara-Manuel, 2022).

In Kenya, FBMHs have been instrumental in providing healthcare since the early 1900s. Their ability to navigate the country's cultural diversity, accommodating different ethnicities, languages, and religious beliefs has been key to their success (Wangila, 2023) Effective communication and cultural competence are crucial in ensuring patient satisfaction and reducing misunderstandings between healthcare providers and patients (Schouten, et al., 2020).

As faith-based mission hospitals continue to expand in Kenya, embracing cultural diversity is a core part of their growth strategy. While challenges like miscommunication and unequal access to care persist, many FBMHs have made significant strides in fostering inclusivity (Wambugu, 2022). To further enhance their impact, these institutions need to focus on creating culturally competent healthcare initiatives and strengthening community collaborations through diversity training.

Cultural Diversity Management

Cultural diversity is a vital strategic asset for organizations aiming to thrive in today's interconnected world. It encompasses various perspectives, experiences, and backgrounds that employees bring to the table, offering a moral and competitive advantage (Austin, 2010). Embracing diversity can drive innovation, enhance decision-making, and improve market reach, contributing to sustainable growth and success (Amegashie, 2018). Diverse teams outperform homogeneous ones, particularly in decision-making, by considering a wider range of options and better anticipating risks, leading to improved outcomes and stakeholder satisfaction (El-Amin, 2022).

FBMHs also benefit significantly from cultural diversity in fulfilling their mission of compassionate care. By fostering cultural competence in patient care and encouraging collaboration, these organizations enhance performance, community trust, and employee retention (Ochieng & Kaseje, 2023). Furthermore, Ahrens & Elias (2023) note that providing multilingual services and improving communication with linguistically diverse patients makes healthcare more accessible and equitable, boosting overall patient satisfaction. Cultural diversity, therefore, not only improves healthcare delivery but also strengthens FBMHs' core values and purpose, allowing them to provide equitable care globally.

Strategic Growth of Mission Hospitals

Mission hospitals engage in strategic growth through service expansion, quality improvement, and sustainability efforts, while facing unique challenges globally (WHO, 2021). Financial sustainability is a key concern, alongside initiatives focused on training healthcare professionals, modernizing medical technology, and implementing health information systems to improve patient care and operational efficiency (WHO, 2015). Many mission hospitals also incorporate community health and preventive care programs, promoting long-term health and wellness in the communities they serve (WHO, 2021).

In Kenya, mission hospitals focus on addressing financial constraints and improving healthcare quality by investing in training, retaining qualified staff, modernizing facilities, and ensuring the availability of essential supplies (MOH Kenya, 2020). Kijabe Hospital, for example, has improved patient outcomes through strategic investments in staff training (Kijabe Hospital, 2022). Additionally, mission hospitals are leveraging telemedicine to expand service delivery and reduce disease burdens in local communities (USAID, 2021). Cultural diversity plays a vital role in strategic growth, as it fosters community trust and ensures that healthcare services

are culturally sensitive and aligned with local values, enhancing health outcomes and promoting sustainable growth (MOH Kenya, 2020).

Profile of Mission Hospitals in Nairobi and Kiambu

Faith-based hospitals in Nairobi and Kiambu counties play a crucial role in addressing the healthcare needs of the population, promoting health equity, and offering compassionate, holistic care (Njoroge, 2020). Despite their significant contributions, these institutions face challenges such as shortages of medical equipment, inadequate infrastructure, limited funding, and difficulties in attracting and retaining skilled healthcare professionals. They also contend with dependence on foreign funding, as well as navigating healthcare regulations and government policies (Chepng'eno, 2023).

Both counties host several well-established faith-based hospitals, categorized as Level 4 and 5 facilities under NHIF guidelines. Kiambu County has 11 such hospitals, including Nazareth Hospital Riara Ridge, St. Immaculate Heart Hospital, and AIC Kijabe Medical Centre, among others. In Nairobi County, there are six notable faith-based hospitals, including Jumuia Hospital Huruma, Neema Hospital Ruaraka, and Mater Misericordiae Hospital. These institutions, managed by religious organizations such as the Catholic Church, African Inland Church (AIC), and Seventh Day Adventist Church, are vital to the region's healthcare infrastructure.

STATEMENT OF THE PROBLEM

Faith-based mission hospitals operate in a complex environment, balancing faith-based values with financial sustainability and competitive staff compensation (Arbuckle, 2000). In addition to engaging in Corporate Social Responsibility (CSR) and adopting strategic frameworks for growth, these hospitals face the challenge of integrating cultural diversity into their operations, as many are founded and managed by individuals from various international backgrounds (Sandal & Trauschweizer, 2022). Embracing diversity in organizational structures and staffing can enhance patient-centered care and improve both financial and non-financial performance (Polanco, 2018).

In Nairobi and Kiambu Counties, faith-based hospitals like Kikuyu Mission Hospital and AIC Kijabe Hospital are vital to healthcare, serving diverse populations with different cultural beliefs (Wanjiku, Kiiru, & Muchangi, 2022). These hospitals face significant challenges, including financial deficits, inadequate medical facilities, and operational inefficiencies, particularly in rural contexts (Wachira & Mwai, 2021). Despite the importance of cultural

diversity training in shaping strategic growth, its role remains understudied, with research often focusing on broader healthcare settings and neglecting the unique dynamics of faith-based institutions. This study sought to address this gap by exploring how cultural diversity training influence the strategic growth of faith-based hospitals in Kenya.

LITERATURE REVIEW

Theoretical Review

Diversity Management Paradigms

Diversity management paradigms put forward by Thomas and Ely (1996) are still very relevant today and have been improved upon recently as more and more organizations see diversity as an essential part of their daily operations. The Discrimination-and-Fairness Paradigm, the Learning-and-Effectiveness Paradigm, and the Access-and-Legitimacy Paradigm are the three diversity management paradigms. These paradigms provide several perspectives on how diversity is managed inside organizations and how it affects the growth and effectiveness of those organizations.

Discrimination and Equity paradigm is centered on following anti-discrimination and equal opportunity laws. Achieving demographic representation in the workforce and making sure that no group is disadvantaged, are the main priorities (Thomas & Ely, 1996; Nishii, 2013). But by concentrating only on compliance, this model can impede innovation and prevent the organization from fully reaping the rewards of diversity. On the other hand, the access-and-legitimacy paradigm recognizes the benefits of cultural diversity in accessing diverse markets or communities. It highlights how diversity can help organizations become legitimate in many cultural contexts by allowing employees to relate to clients and customers from a range of ethnic backgrounds. Although this paradigm is more sophisticated than the discrimination-and-fairness model, one of its limitations is that it frequently sees diversity from a transactional perspective. Employees from diverse backgrounds may feel undervalued for their broader skills and contributions if they are only seen as tools to access specific markets. The Efficiency and Learning Paradigm incorporates diversity into the fundamental operations of the organization. It sees diversity as an asset that improves the efficacy and learning of organizations. In addition to emphasizing demographic representation, the goal is to foster an inclusive atmosphere where all viewpoints are actively included in the processes of innovation, problem-solving, and decision-making. The learning-and-effectiveness paradigm promotes ongoing learning and adaptation, which optimizes the advantages of diversity. It promotes an

inclusive and cooperative atmosphere by enabling organizations to strategically grow by utilizing the varied experiences and ideas of their workforce (Roberson, 2019).

This theory was important in informing cultural diversity training framework, whereby the theoretical postulations can assist FBMHs in going beyond compliance. Theoretically, they should strive toward transitioning from the paradigms of discrimination and fairness to more inclusive ones, like the learning-and-effectiveness paradigm, which provides long-term advantages in terms of growth, innovation, and employee satisfaction. Faith-based mission hospitals should train the staffs on the access-and-legitimacy paradigm not only in strategic application to better serve a variety of patient populations, but also in transition to the learning-and-effectiveness paradigm in order to improve organizational growth and healthcare delivery.

Despite the fact that Thomas and Ely's (1996) paradigms provide an organized approach to diversity management, organizations are shifting their attention to the learning-and-effectiveness paradigm because of its long-term advantages. Contemporary studies, such those by Nishii (2013) and Roberson (2019), support the development of inclusive settings that encourage creativity and diversity-based learning. Organizations that adopt this paradigm can increase organizational effectiveness through deeper cultural integration in addition to achieving compliance and market access.

Hofstede's Cultural Dimensions Theory

Hofstede's Cultural Dimensions Theory, introduced by Geert Hofstede in 1980, offers a framework for understanding cultural differences and their impact on various societal aspects, including organizations (Rojo, Everett, Ramjan, Hunt & Salamonson, 2020). It identifies six dimensions: Power Distance, Masculinity vs. Femininity, Individualism vs. Collectivism, Uncertainty Avoidance, Long-term vs. Short-term Orientation, and Indulgence vs. Restraint. These dimensions help in managing cross-cultural interactions by highlighting variations in norms, values, and behaviors (Taras, Steel, & Stackhouse, 2023). For Faith-Based Mission Hospitals (FBMHs) in Kenya, Hofstede’s theory provides insights into how cultural diversity training could improve organizational operations and strategic growth. Notably, Kenya's high-Power Distance indicates a hierarchical culture, influencing management and decision-making, while a Collectivist orientation suggests a focus on group harmony in patient care and collaboration (Cheruto, 2021). Understanding through training on these cultural traits can enhance strategic initiatives and improve organizational effectiveness in diverse healthcare settings.

The Resource-Based View (RBV)

The Resource-Based View (RBV), developed by Edith Penrose in 1959, emphasizes that a firm's unique resources and capabilities are critical for achieving a long-term competitive advantage. According to RBV, rare and valuable resources, whether tangible or intangible can sustain competitive edge and enhance performance. For FBMHs, cultural diversity itself can be a strategic asset, offering opportunities for innovation and improved responsiveness to diverse patient needs. Effective management of cultural diversity, through practices like cultural competency training, aligns with RBV's focus on leveraging unique resources to gain competitive advantages. By integrating RBV, FBMHs can align their strategic goals with the cultural diversity of their stakeholders, improving organizational performance and adaptability in a dynamic healthcare environment.

EMPIRICAL LITERATURE

A study by Young and Guo (2020) highlights that cultural diversity training improves healthcare professionals' cultural competence, communication, and patient care. By offering such training, faith-based mission hospitals (FBMHs) can enhance patient satisfaction, treatment adherence, and health outcomes, while better serving their diverse populations and attracting new patients. This research sought to assess the extent to which FBMHs in the study area implement cultural diversity training.

Hussain et al. (2020) found that diversity training initiatives in the UK's National Health Service help attract and retain a diverse workforce, contributing to innovation, creativity, and problem-solving. FBMHs could benefit similarly by fostering an inclusive workplace where staff feel valued, thus improving organizational performance and driving strategic growth. Furthermore, diversity programs raise awareness of healthcare disparities, enabling providers to address inequities in patient care according to a study by Martinez and Mahoney (2022). This promotes health equity and allows FBMHs to expand their reach and strengthen partnerships with underserved populations.

Diversity training also fosters a culture of sensitivity and respect in service delivery. Research by Flores et al. (2016) and Kagawa-Singer et al. (2010) shows that culturally tailored care improves patient satisfaction and community trust, positioning FBMHs for strategic growth. Additionally, by engaging with community organizations and cultural groups, FBMHs can expand their networks and uncover new opportunities for development.

RESEARCH METHODOLOGY

This study employed a descriptive research design, a design that facilitated data collection in order to provide a description of the variables under investigation. The design allowed measuring, analysis, and interpretation of data. The study employed a stratified sampling technique to ensure adequate representation of all groups in the target population. The population was divided into homogeneous subgroups or strata based on specific attributes, such as Chief Executive Officers, Corporate Managers, doctors, specialists, Clinical Officers, and nurses. Samples were then randomly selected from each stratum proportionally within each hospital.

The study collected primary data using a structured questionnaire divided into sections for demographic information and research variables. Quantitative data was gathered through Likert scale items and analyzed using a computer program. Questionnaires were distributed via email or Google documents and collected by mail, while physical copies were dropped off and picked up later to accommodate the busy schedules of healthcare workers.

The research instrument underwent both validity and reliability tests. Validity, which measures how well the instrument captures the intended data, was improved through feedback from supervisors and lecturers at St. Paul's University and a pilot survey involving 10% of the target population (43 respondents) who did not participate in the main study. Reliability, indicating the instrument's consistency and dependability over time, was tested using the test-retest method and Cronbach's alpha. The test-retest method assessed consistency by administering the same test twice over two weeks, while Cronbach's alpha measured the internal consistency of the items, with a coefficient of 0.7 or higher indicating adequate reliability. SPSS software was used to support these analyses.

The study employed both quantitative and qualitative methods for data analysis. Descriptive statistics provided frequencies, percentages, and standard deviations, while inferential statistics, including regression analysis and Pearson correlation, examined relationships between research variables.

The univariate regression model used was $Y=\beta_0+\beta X+\varepsilon$

Where;

Y represents strategic growth

β_0=Constant,

X = Diversity Training

β = Beta coefficients

ε is the error

The study adhered to ethical guidelines established by St. Paul's University Ethical Committee. It secured approvals from the University, the National Commission for Science, Technology and Innovation (NACOSTI), and the management of participating hospitals before commencement. To ensure confidentiality, the study protected respondents' identities, encouraging accurate information sharing. The researcher committed to presenting findings transparently and accurately, and all referenced materials were duly acknowledged to prevent plagiarism.

FINDINGS AND DISCUSSION

Out of the 234 sampled individuals targeted 223 filled up the questionnaires. This means that the overall response rate was 95.3% represented in all the hospitals. The general demographic data revealed that 55.5% of respondents were male and 44.5% were female. The majority were aged above 45 years (39.8%), with 35.4% in the 26-35 years bracket, indicating a mature workforce. Most respondents (51.2%) held a bachelor's degree, followed by 37.4% with a master's degree, and 11.4% with a diploma, showing a highly educated group with a focus on higher education.

In terms of job roles, 25.2% were allied health professionals, 20.9% were medical staff (including physicians and surgeons), 17.3% were administration staff, and 16.5% were medical officers. Employment levels were distributed with 46.1% in middle management, 28.0% at junior or entry level, and 26.0% at senior levels, indicating a strong representation of mid-career professionals. Regarding years of service, 54.7% had served between 16-20 years, 28.7% between 11-15 years, and 16.5% for less than 5 years, reflecting a well-experienced workforce whose insights are likely to be reliable.

Descriptive Analysis

The study assessed how diversity training influences the strategic growth of Faith-Based Mission Hospitals in Kiambu and Nairobi Counties. Results showed that the hospitals' provision of comprehensive diversity training programs received a mean score of 3.57 (standard deviation = 0.872), indicating a general agreement on the presence of such programs.

However, the effectiveness of these sessions in enhancing staff cultural competence had a mean score of 3.37 (standard deviation = 0.784), suggesting varied perceptions on their impact.

Regarding improvements in employee performance and attitudes towards cultural diversity, the mean scores were 2.91 (standard deviation = 0.654) and 3.28 (standard deviation = 0.948), respectively, reflecting uncertainty among respondents. Training's impact on collaboration between staff from different cultural backgrounds had a mean score of 2.76 (standard deviation = 0.772), indicating a tendency towards disagreement or uncertainty. On the other hand, training's effectiveness in addressing cultural issues in patient care scored 3.63 (standard deviation = 0.773), and increasing awareness of health disparities scored 3.83 (standard deviation = 1.043), showing general agreement with some uncertainty. Lastly, the contribution of diversity training to organizational success had a mean score of 3.47 (standard deviation = 0.783), indicating mixed responses between agreement and uncertainty.

Correlation Analysis

The study conducted correlation analysis to examine the linear relationship between variables. The analysis aimed to summarize the existing connections and to providing insights into their associations and measuring the extent of their linear relationship. This helps in understanding how the independent variable relates to the dependent variable and can clarify cause-and-effect relationships.

Table 1: Correlation between Diversity Training and Strategic Growth

		Diversity Training	**Strategic growth**
Diversity Training and	Pearson Correlation	1	.863**
	Sig. (2-tailed)		.000
	N	223	223
Strategic growth	Pearson Correlation	.863**	1
	Sig. (2-tailed)	.000	
	N	223	223
**. Correlation is significant at the 0.01 level (2-tailed).			

The Pearson Correlation coefficient of 0.863 reveals a very strong positive relationship between diversity training and the strategic growth of faith-based hospitals. This indicates that as diversity training increases, there is a significant rise in strategic growth. The significance level of 0.000 confirms that this correlation is statistically significant at the 0.01 level ($p < 0.01$), meaning the observed relationship is highly unlikely to be due to chance. This strong

correlation underscores the critical role of diversity training in enhancing strategic growth, suggesting that investing in such initiatives can lead to improved patient care, employee satisfaction, and overall organizational success.

Regression Analysis

Regression analysis between the two variables gave the following outcome.

Table 2: Regression Results

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Diversity Training	.893	.013	1.240	67.358	.000
a. Dependent Variable: Strategic Growth					

The FBMHs implemented comprehensive diversity training programs that received mostly positive feedback for enhancing staff cultural competence and sensitivity. While the training was effective in improving staff attitudes towards cultural diversity and raising awareness about health disparities, there was some uncertainty about its overall impact on performance and staff collaboration. Despite mixed opinions, the training was deemed crucial for advancing cultural competence, fostering better staff collaboration, and supporting the hospitals' overall success.

CONCLUSION

The diversity training programs implemented by the FBMHs have been largely effective in enhancing staff cultural competence and sensitivity, with positive feedback from most respondents. However, there is some uncertainty about the training's overall impact on performance and staff collaboration. While the training has improved staff attitudes towards cultural diversity and increased awareness of health disparities, opinions are mixed regarding its effectiveness in fostering better teamwork. Overall, the training is deemed crucial for advancing cultural competence and supporting the hospitals' success, though further efforts may be needed to address issues related to staff performance and collaboration.

RECOMMENDATIONS

i. Hospital administrators and leaders should ensure availability of effective multilingual informational resources to address language barriers in diversity training.

ii. FBMH'S leadership should incorporate comprehensive cultural competence modules into training programs for staff.

iii. FBMHs' management should continuously refine diversity training programs based on feedback from patients and staff.

iv. FBMHs Leadership should actively and continually gather feedback from stakeholders to enhance cultural competence in training programs.

REFERENCE

Amegashie, A. R. (2018). *Diversity Management Program Strategies To Support Competitive Advantage And Sustainable Growth.* Washington MN: Walden University.

Arbuckle, G. A. (2000). *Healthcare Ministry: Refounding The Mission in Tumultuous Times.* Collegeville, Minnesota: Liturgical Press.

Austin, J. E. (2010). *The Collaboration Challenge: How Nonprofits and Businesses Succeed Through Strategic Alliances* . New York: John Wiley & Sons.

Chepng'eno, C. (2023). *The Catholic Church's Efficacy in Alleviating Normative Challenges in Healthcare Provision in The Catholic Diocese of Kericho.* Kakamega: Masinde Murilo University of Science and Technology.

Cheruto, S. K. (2021). *How the Healthcare-Seeking Socio-Cultural Context Shapes Maternal Health Clients' in Health Utilization in a Kenyan Context.* Cape Town, SA: University of Cape Town.

El-Amin, A. (2022). Improving Organizational Commitment to Diversity, Equity, Inclusion, And Belonging. In. *Social Justice Research Methods for Doctoral Research*, pp. 208-221.

Freeman, R. E., Dmytriyev, S. D., & Phillips, R. A. (2021). Stakeholder Theory and The Resource-Based View of The Firm. *Journal of Management, 47*(7), 1757-1770.

Fubara-Manuel, J. I. (2022). *Role of Christian Faith for Women Living with Disabilities and HIV in South-South Nigeria.* Edinburgh UK: University of Edinburg.

Gibson, C. B., Gibson, S. C., & Webster, Q. (2021). Expanding Our Resources: Including Community in The Resource-Based View of The Firm. *Journal of Management, 47*(7), 1878-1898.

Hamdoun, M. (2020). The Antecedents and Outcomes of Environmental Management Based on The Resource-Based View: A Systematic Literature Review. *Management of Environmental Quality: An International Journal, 32*(1), 451-469.

Iruthayasamy, L., & Iruthayasamy, L. (2021). The Resource-Based View. Understanding Business Strategy. *Confusion and Consensus*, pp. 63-74.

Kengia, J. T., & Nelson, C. (2020). Transforming Healthcare Services Through Faith-Based Organization: A Case Study of Faith-Based Hospitals in Cameroon. . *Journal of Healthcare Leadership*(12), 1-9.

Kijabe Hospital. (2022). *Annual Report 2022.* Nairobi, Kenya: Kijabe Hospital.

Lubis, N. W. (2022). Resource Based View (RBV) in Improving Company Strategic Capacity. *Research Horizon, 2*(6), pp. 587-596.

Minkov, M., & Kaasa, A. (2021). A test of Hofstede's Model of Culture Following His Own Approach. *Cross Cultural & Strategic Management, 28*(2), 384-406.

MOH Kenya. (2020). *Kenya Health Sector Strategic Plan 2020-2025*. Nairobi, Kenya: Ministry of Health, Kenya.

Njoroge, B. W. (2020). *Factors of Access to Healthcare Services Among the Ageing Population: A Case of Hospital Support Organization at African Inland Church Kijabe Hospital, Kenya.* Nairobi: university of Nairobi.

Njuguna, K. T., Alkizim, A. O., & Njuguna, M. (2022). Cross-Cultural Project Management in International Construction Projects in Kenya. *In Proceedings of the Sustainable Research and Innovation Conference* (pp. 202-206). Nairobi: Jomo Kenyatta University of Agriculture and Technology.

Norris, P. H. (2021). *A Missional Resurgence: Helping Bridges Church Rediscover Her Missional Purpose Resulting in Vibrant Growth.* Lynchburg VA USA: Liberty University.

Ochieng, B., & Kaseje, D. (2023). *The Effectiveness of Community Health Care Programs.* Newcastle upon Tyne, England: Cambridge Scholars Publishing.

Olivier, J., & Wodon, Q. (2014). *Health Services Delivery and Faith-Based Organizations: A Resource Guide for Faith-Based Organizations Providing Health Services.* New York: World Bank Publications.

Polanco, A. A. (2018). *The Process of Adoption of Disruptive Innovations in Local Health Care Agencies Delivering Primary Care.* El Paso, TX, USA: The University of Texas at El Paso.

Rojo, J., Everett, B., Ramjan, L. M., Hunt, L., & Salamonson, Y. (2020). Hofstede's Cultural Dimensions as The Explanatory Framework for Performance Issues During Clinical Placement: A Mixed Methods Study. *Nurse Education Today, 94*.

Sandal, N. A., & Trauschweizer, I. (Eds.). (2022). *Religion and Peace: Global Perspectives and Possibilities.* Athens, Ohio: Ohio University Press.

Schouten, B. C., Cox, A., Duran, G., Kerremans, K., Banning, L. K., Lahdidioui, A., & Krystallidou, D. (2020). Mitigating Language and Cultural Barriers in Healthcare Communication: Toward a Holistic Approach. *Patient Education and Counseling, 103*(12), p. 2604.

Taras, V., Steel, P., & Stackhouse, M. (2023). A Comparative Evaluation of Seven Instruments for Measuring Values Comprising Hofstede's Model of Culture. *Journal of World Business, 58*(1).

USAID. (2021). *Kenya Health Program Report.* New York: United States Agency for International Development.

Wachira, B. W., & Mwai, M. (2021). A Baseline Review of The Ability of Hospitals In Kenya to Provide Emergency and Critical Care Services For COVID-19 patients. *African Journal of Emergency Medicine, 11*(2), 213-217.

Wambugu, P. (2022). *Dynamics of Anglican Development Services of The Anglican Church in Enhancing Community Development in Kenya.* Chuka, Meru Kenya: Chuka University.

Wangila, M. N. (2023). *Religion and the Cultures of Kenya: The Palgrave Handbook of Contemporary Kenya.* Cham: Springer International Publishing.

Wanjiku, G., Kiiru, G., & Muchangi, D. (2022). Influence of Competencies, Resources, and Competitive Orientation on the Performance of Faith-Based Hospitals in Kenya. *International Journal of Managerial Studies and Research (IJMSR), 10*(8), 11-21. doi:https://doi.org/10.20431/2349-0349.1008002

WHO. (2015). *Global Health Workforce Shortage to Reach 12.9 Million in Coming Decades.* Geneva, Switzerland: World Health Organization.

WHO. (2021). *Public-Private Partnerships for Health.* Geneva, Switzerland: World Health Organization.

Winiger, F., & Peng-Keller, S. (2021). Religion and the World Health Organization: An Evolving Relationship. *BMJ Global Health, 4*.

Zhao, X., Liang, J., & Dang, C. (2019). A Stratified Sampling-Based Clustering Algorithm for Large-Scale Data. *Knowledge-Based Systems*(163), pp. 416-428.