

**COMMUNITY PARTICIPATION AND HEALTH SERVICE DELIVERY IN  
SELECTED HEALTH UNITS IN MUKONO MUNICIPALITY**

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13/U/2037/GMOP/PE**

**A RESEARCH REPORT SUBMITTED TO GRADUATE SCHOOL IN PARTIAL  
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**JANUARY 2016**

**DECLARATION**

I, Marachto Shirley declare that, this research dissertation is my original work and has never been submitted to any institution of higher learning for any award.

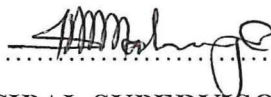
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## APPROVAL

This is to certify that this dissertation is submitted for examination in partial fulfillment for the award of a Master's Degree in Science of Organizations and Public Policy Management with our approval as University Supervisors.

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## **DEDICATION**

I dedicate this dissertation to the Almighty God who always blessed me in all my endeavors, my parents Mr. and Mrs. Watum Ongom Richard, my brother Joshua Wadape, my uncle Kalisa Ongom Uyuru, all my relatives, friends and course mates who have always encouraged me and supported me in one way or another.

## LIST OF ACRONYMS/ABBREVIATIONS

AIA	:	American Institutes of Architectures
ANC	:	Antenatal Care
AND	:	Asian Neighborhood Design
ARC	:	Architecture-Research-Construction
ARCH	:	Architectural Renewal Committee in Harlem
ARV	:	Antiretroviral Therapy
C.E.H.M	:	Center for Ethnicity and Health Community Engagement Model
C.H.E	:	Community participation and Health Educator Model
CCF	:	Christian Children Fund
CDBG	:	Community Development Block Grants
CDC	:	Community Design Centres
CHW	:	Community Health Workers
DOT	:	Direct Observation Treatment
GoU	:	Government of Uganda
HCAHPS	:	Hospital Consumer Assessment of Health Care Providers and Assessment
HCC	:	Health Centre Committees
HIV/AIDS	:	Human Immune Virus/ Acquired Immune Deficiency Syndrome
HPM	:	Health Promotion Model
HSD	:	Health Service Delivery
HSSP	:	Health Sector Strategic Plan
IMCI	:	Integrated Management of Child illness
IMR	:	Infant Mortality Rate
M.D.G	:	Millennium Development Goals
MMHMT	:	Municipality Health Management Teams
MMR	:	Maternal Mortality Rate
MoH	:	Ministry Of Health
NDP	:	National Development Plan
NGOs	:	Non Governmental Organisations
NHC	:	National Health Council
P.D.M	:	Participative Decision Making
PHC	:	Primary Health Care
PMTCT	:	Prevention of mother to child transmissions
PNFP	:	Private not For Profit
RDT	:	Rapid Diagnosis Testing
SPSS	:	Statistical Packages for Social Sciences
STI	:	Sexually Transmitted Infections
TB	:	Tuberculosis
TBA	:	Traditional Birth Attendant
UNBS	:	Uganda National Bureau of Standards
USAID	:	United States Agency for International Development
VCT	:	Voluntary Counseling and Testing
VHC	:	Village Health Committees
VHT	:	Village Health Teams
WHO	:	World Health Organization

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**May the Almighty God bless you all!**

## ABSTRACT

The overall objective of this study was to investigate how “**Community Participation impacts Health Service Delivery in selected Mukono Municipality Health Centres**”. This was guided by the following specific objectives to; examine the influence of participative decision making on health service delivery in Mukono Municipality, assess the effect of information sharing on health service delivery in Mukono Municipality and evaluate how consistent community feedback leads to health service delivery in Mukono municipality.

The study adopted a case study research design. A sample size of 195 respondents comprising of health workers (doctors, nurses, medical assistants, clinic officers and midwives) were selected from two Health Centres and one hospital (health centre IV, Kyungu health centre III and Mukono Church of Uganda Hospital) and community members living in Kauga village, Nassuti village and Mukono centre, chairpersons of village Health Committees (VHCs), Community Health Workers (CHWs), councilors and the Municipality Medical Officer. Both primary and secondary data were used for this research. Qualitative and quantitative data was used for the study. Both primary and secondary data was collected using self-administered questionnaires, focused group discussions and an interview guide. Qualitative data was analysed by transcribing it into the major themes which emerged. Quantitative data was analysed using Statistical Packages for Social Sciences (SPSS).

The findings of the study revealed there was a strong positive correlation between community participation and health service delivery ( $r = 0.883$ ;  $p < 0.005$ ). The study findings were that low community participation resulted into shortage of skilled health personnel, lack of equipment, stock outs of drugs and low budgetary allocation which hampered delivery of primary health care. This attributed to obstacles in accessing health care services. The study concludes that, there is Relationship between participative decision making, information sharing *and* consistent community feedback ( $r = .925^*$ ;  $p = 0 < 0.035 < 0.05$ ). The study results therefore show that participative decision making had a positive effect on health service delivery. This is explained by the positive correlation co-efficient between the two variables ( $r = 0.303$ ). Low levels of participation in decision making made health service insignificant within the Mukono Municipality community; this resulted into high level of mortality and morbidity due to preventable and treatable diseases. There is a strong relationship between information sharing and health service delivery ( $r = .052$ ;  $p = 0.73 > 0.05$ ). community participation (Participative Decision Making ( $P_{dm}$ ), Information Sharing ( $I_s$ ) & Feedback( $F$ ) explain 62.5% of variations in health service delivery. Results show a significant model ( $F=7.002$ ,  $sig=0.003$ ) to explain a multi regression equation of health service delivery ( $y$ ) =  $1.172+0.326(P_{dm}) + 0.260(I_s) + 0.458F$

The study recommends that, the number of primary health care facilities be increased and human resources management and administration should be strengthened to avert staff shortages in health facilities. A contingency plan for the supply of drugs and equipment to health facilities should be developed. Budgetary allocation to health facilities should be increased as well as scaling up on community health system strengthening.

## **CHAPTER ONE INTRODUCTION**

### **1.0 Introduction**

The study was set out to examine the relationship between community participation and health service delivery in the Health units of Mukono Municipality. Community participation in health service delivery was therefore emerged as an imaginative; as a new approach which seeks to bring together the formal profession, the health structure and the local people with their knowledge and resources,(Cornwall, 2000). Hence this chapter presents the background to the study, statement of the problem, purpose of the study, objectives of the study, research questions, scope of the study, significance of the study, and the conceptual framework.

### **1.1 Background of the Study**

Community participation originated way back in the early 1960's when direct involvement of the public in the definition of its physical environment and an increased sense of social responsibility constituted a new movement. Following this movement, Community Design Centers (CDCs), aiming to offer design and planning services to enable the poor to define and implement their own planning goals, were established in the United States. The 1960s and early 1970s was a time of great organizational flourishing. Organized in 1963, the Architectural Renewal Committee in Harlem (ARCH) fought a proposed freeway in Upper Manhattan. In Cleveland, Architecture-Research-Construction (ARC) remodeled hospital wards, community-based treatment centers and group homes, working with patients, staff and administrators in a participatory design process (WHO 1978)

Founded in 1973, Asian Neighborhood Design (AND) began working on issues in San Francisco's Chinatown. In response to the economic and political pressures of the 1980s, some CDCs remained project-based. Such a center is generally organized as a non-profit by an administrator through a local American Institute of Architects (AIA) chapter, and supported by Community Development Block Grants (CDBG) and other sources of funding, ( WHO, 2008).

In Africa, Health service delivery started way back in the early 1970s as to uplift the basic health needs of the local people themselves through their involvement. In order to ensure universal access to healthcare, the 1978 Alma Ata declaration stressed that PHC shall be the key to

attaining health for all by 2000 and beyond in the spirit of social justice (WHO 1978) cited in a (Auma 2011).

Consequently, in 2001, Uganda developed the Village Health Teams (VHT) strategy as an innovative approach to: empower communities to participate in their own health; strengthen the delivery of health services at both community and household level and as a means to realize the Alma Ata declaration. Through this innovative strategy, Primary Health Care would be implemented as a way to ensure universal access to health care for all. (MoH 2011)

Mukono Municipality Health Report (2014), indicates that ill health in the community being; 43.2% -malaria, institutional deliveries attended to by skilled and trained health workers prevailed at 40%, although 93% of pregnant women attended antenatal (ANC) at least once, maternal mortality rate and infant maternal mortality stand high with adolescent fertility rate at 32%.

The study adopted a theory of Decentralization and Development by Cheema S, etal (1983) which was modified by Falleti, T. (2003).

Community participation is defined as activities undertaken by communities through mobilization of member groups in order to deliver a service. The Processes of community participation entails activities such as information sharing, consultation, involvement, participation and empowerment, (USAID 2010).

Community participation in health is a process by which members of the community either individually or collectively and with varying levels of commitment; develop the capability to assume greater responsibility for assessing their health needs and problems, plan and then act to implement their solutions, create and maintain originations in support of these efforts and evaluate the effects and bring out necessary adjustments in goals and programs on an ongoing basis. Community participation is therefore a strategy that provides people with a sense that they can solve their problems through careful reflection and collective action while many individual factors contribute to the achievement of greater community Participation in Health. Collective wisdom hold that the collective core value of community participation is that it provides a mechanism for people to participate in activities that have the potential to impact positively upon their health. (WHO 2008)

Health service delivery refers to services rendered by members of health profession for the benefit of a patient or the physical presence of delivery of a health service that meets a minimum

standard with characteristics such as comprehensiveness, accessibility, coverage, quality, coordination, efficiency and performance. Inadequate Health service delivery affects Child Health, quality of Health in terms of (social, mental, psychological, environmental health), Reproductive Health Care, Oral Health and Hygiene, Health Education and promotion and Environmental Health. Health activities are carried out more appropriately when the community is given greater control. Greater local involvement is thought to decrease feelings of alienation on the part of the community and foster less authoritative relationships between the community and health official. All of these benefits are believed, ultimately to have a positive impact in health. (Crigler 2009)

Approximately 6000 women die each year due to pregnancy related factors). It is estimated that over 60% of women seek care from Traditional and Complementary Medicine Practitioners for example Herbalists, Traditional setters, Traditional Birth Attendants before and after visiting the formal sector MoH, (2013). Report on Health Sector Strategic plan HSSP, (2014/2015) showed that over 68% of pregnant mothers do not deliver from hospitals with over a half of the total new born deaths occurring in the first week of life mainly within the first 24 hours which poses a great threat to the lives of both the mother and the unborn child. A report by NDP (2014/2015) shows that 54% of disease in Mukono Municipality arises due to, lack of adequate child care, poor environment characterized by poor Hygiene and Sanitation and improper waste management posing a threat to the lives of the community members.

## **1.2 Statement to the Problem**

Despite the fact that community participation enhances the effective utilization and active involvement in decisions making about the health programme policies and activities, service delivery in health centers of Mukono municipality have remained poor (Wamanga 2013). It is evidenced that infant mortality rate is high at 56% annually, Maternal death is 58% and 54% of the total burden of diseases arise due to poor sanitation and environmental hygiene, limited number of pit latrines, poor solid waste management and garbage disposal, (UNBS report, 2014). This could be attributed to lack of commitment and active involvement of the community, conflicting personal and community agendas. Consequently, if this continues, Mukono municipality is more likely to register high maternal mortality rate, high infant mortality rate, presence of many killer diseases like Bilharzias, HIV/AIDS, Malaria, tuberculosis, bilharzias, and sleeping sickness which in turn will retard the quality of the population, reduce the life span

and hike death rates among the population. Therefore, this prompted the need to conduct a study to examine the effect of community participation on health service delivery in Mukono Municipality.

### **1.3 General Objective**

To examine the relationship between Community Participation and Health Service Delivery in Mukono Municipality:

### **1.4 Specific objectives to the Study**

- i) To examine the influence of participative decision making on health service delivery in Mukono Municipality.
- ii) To assess the relationship between information sharing on health service delivery in Mukono Municipality.
- ii) To evaluate how consistent community feedback leads to health service delivery in Mukono municipality.

### **1.5 Research Questions**

- i) To what extent does participative decision making influence health service delivery in Mukono municipality?
- ii) What is the relationship between information sharing and health service delivery in Mukono Municipality?
- iii) How does consistent feedback promote health service delivery in Mukono Municipality?

### **1.5 Scope of the Study**

#### **1.5.1 Content Scope**

The study focused on examining the relationship between Community Participation (independent variable) and Health Service Delivery (dependent variable) in Mukono Municipality. Community participation was measured using the extent to which citizens of Mukono municipality participated in personal decision making, level of information sharing about health related matters among the people with health workers and also the extent to which feedback improved health service delivery. The measures of health services delivery involved examining the quality of health care among the children, reproductive mothers and generally the environmental health related concerns in Mukono municipality.

### **1.5.2 Geographical Scope**

The study was conducted from Mukono Municipality in Mukono district. Mukono District lies in the Central region of Uganda, along Kampala-Jinja road (21Kms East of Kampala City). The municipality serves as an Administrative and commercial centre

### **1.5.3 Time scope**

The study took ten months, from February to November, 2015. The literature covered the past 15years while data on health service delivery challenges were examined for the past 3years.

### **1.6 Significance of the Study**

The findings of the study will provide vital information to government to embrace the community in decision making processes. This will help to transform the health status local people in the community through instituting effective and efficient service delivery.

The study findings may be utilized by policy makers and health care administrators with evidence based information on constraints faced by primary health care facilities in communities. This will enable them to design viable interventions aimed at improving health care service delivery.

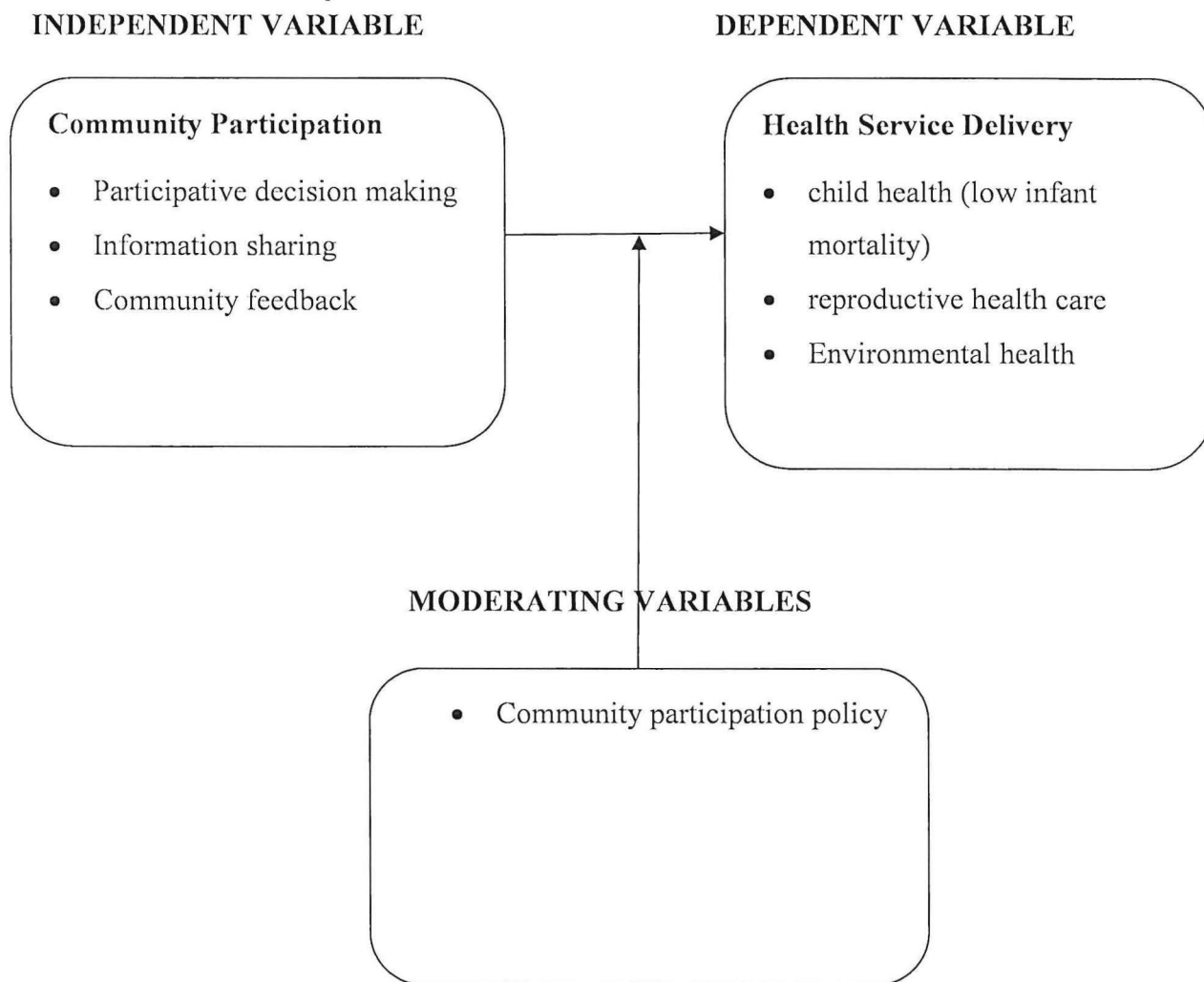
The district health department may use the study results to identify gaps in health care centres such as availability of health facilities, supply chain of drugs, vaccines, equipment, personnel, budgetary allocation, access to health services by people in the community and strengthen participation in health care services.

The findings of the research are expected to enrich community participation through creating health awareness issues in Mukono and other parts of the country. This will help to improve equitable access to social services and infrastructure development. At the individual level, people were still not able to take care of their own health as there were negative attitudes towards community participation in primary health care.

The results of the study will also add to existing body of knowledge by reviewing literature. This will help to create a change in people’s initiatives and awareness on their rights with regards to health service delivery

### 1.7 Conceptual Frame Work

**Figure 1: Illustrating the Conceptual Framework regarding Community Participation and Health Service Delivery**



*Source: Adopted from Jabbar (2011) and modified by the researcher*

The conceptual frame work developed according to Jabbarl (2011) highlights the activities in Community participation as Participative decision making, information sharing and community feedback According to Jabbar (2011), Participative decision making is effective through formation of small groups that is representative of the community of interest or focus group

discussions, single or multiple opportunities of face to face meeting with a focus on understanding the perceptions, beliefs and attitudes of people on a health related topic.

According to Jabber (2011), such focus groups lead to communication and exchange of relevant information on issues of health, involvement of experts to answer participants' questions and co production of a set of recommendations from the group's deliberation.

Jabbar (2011) also stresses that regular feedback that is actively sought is an important strategy for optimizing partnerships and collaborating organizations should aim to include all stakeholders in the feedback process, including community members and policy makers. Multiple and diverse approaches to seeking and using feedback should be developed, and the effectiveness of these approaches should be assessed and improved upon on a regular basis.

The authors compared rankings of health priorities a face-to-face meetings to generate information sharing and feedback to the communities and found out that with increased deliberation, participant views were more amenable to change (Jabbar 2011), illustrating the potential for deliberation to encourage consensus building hence effective service health delivery with multiple indicators such as quality Child Health (Low infant Mortality Rate), improved Reproductive Health and enhanced Environmental Health.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

The study involved a comprehensive review of background documents, reports and journals on community participation and health service delivery. While literature on the topic of community participation is extensive, only articles relevant to understanding community participation for the purpose of improving health were reviewed. Excluded literature discussed community engagement for the purpose of addressing environmental issues (e.g. cleaning up of oil spills, developing safe water strategy, mining, cultural planning, and urban planning). While these issues are also intricately linked to health of the community, the focus was on the concept of advocacy, situated within politically charged settings where the relationship between the statutory agency and the community was tenuous.

#### **2.2 Theoretical Review**

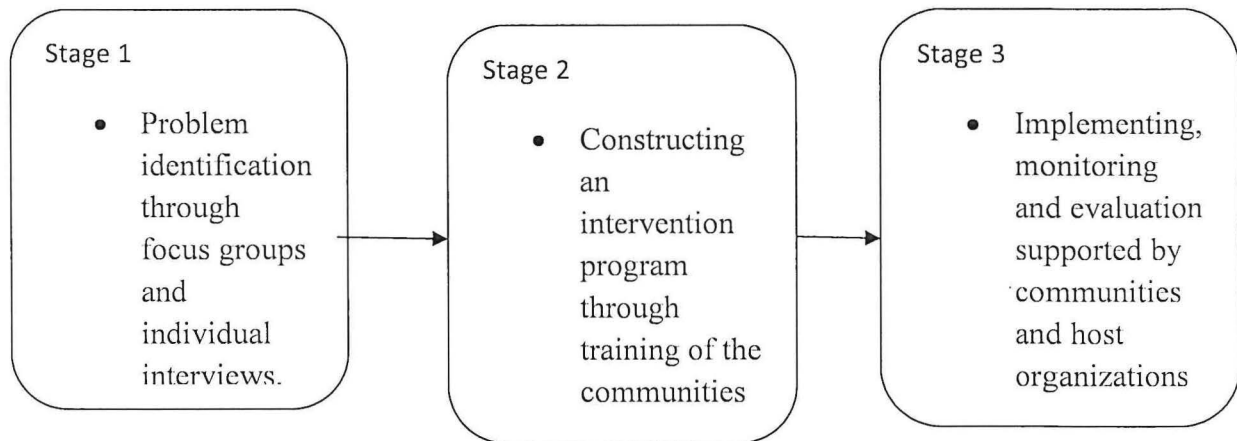
##### **2.2.1 The sequential theory of decentralization**

The study adopted the theory of Decentralisation and Development to assist in analysis of the concept of community participation and health service delivery. The theory has three main characteristics; it defines decentralization as a process, it takes into account the territorial interests of bargaining actors, and it incorporates policy feedback effects. Sequencing of different types of decentralization (fiscal, administrative, and political) is a key determinant of the evolution of intergovernmental balance of power, (Cheema et al 1983).

Administrative decentralization comprises the set of policies that transfer the administration and delivery of social services such as education, health, social welfare, or housing to sub national governments. Administrative decentralization may entail the devolution of decision-making authority over these policies, but this is not a necessary condition. Fiscal decentralization refers to the set of policies designed to increase the revenues or fiscal autonomy of sub national governments. Fiscal decentralization policies can assume different institutional forms such as an increase of transfers from the central government, the creation of new sub national taxes, or the delegation of tax authority that was previously national. Political decentralization is the set of constitutional amendments and electoral reforms designed to open new or activate existing but dormant or ineffective spaces for the representation of sub national politics. Political

decentralization policies are designed to devolve political authority or electoral capacities to sub national actors, (Cheema et al 1983).

**Figure 2: The Community participation and Health Educator (CHE) model**



*Source: Chiu, 2008, pg 152 modified by Lane and Tribe 2010*

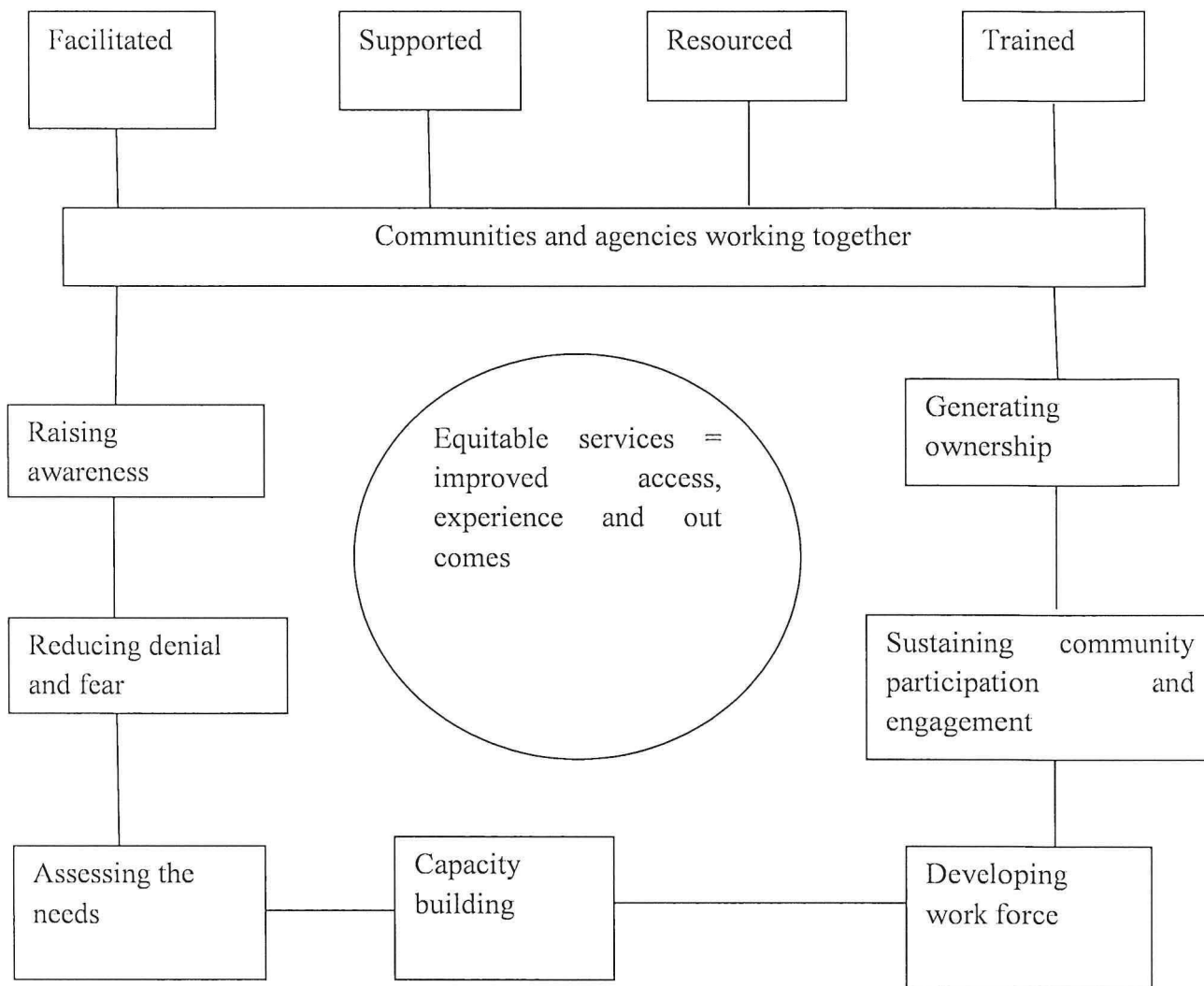
Lane and Tribe (2010) offered to simplify the administrative aspect of the decentralization sequential theory by coming up with a three-step practical model guide on community participation. Based on their work with communities they found out that one of the major tasks in Step 1 is finding a local organization that is willing and able to partner in identifying of the problems in the community.

To avoid selecting an organization whose views may not reflect that of the greater community, the authors suggested spending sufficient time within the community in order to decide which organization to engage with. While it is important to develop a meaningful partnership with a community, this process can be challenging for health agencies. Indeed, barriers in access to and acceptance by communities may hinder the early establishment of common goals. Other factors to consider during this stage of the engagement include recognizing culture-specific beliefs about health, ethical concerns, timing and commitment of consultation events, and interpretative services (if applicable).

During the consultation phase, Lane and Tribe (2010) highlighted two essential elements: practical considerations – informing participants of what is required of them, and frequency of consultation events. The authors advocated for one-to-one sessions with participants, wherever possible, over group sessions in order to decrease domination of the outcome by community members who may be opinionated (Lane & Tribe, 2010).

In the last stage of implementation, the ideas generated in step one and discussed in stage 3 are then implemented and frequent monitoring and evaluation is carried out by the community members in partnership with the selected local organizations and stakeholders.

**Figure 3: Center for Ethnicity and Health Community Engagement Model**



*Source: Fountain et al, (2007)*

The aim of the model was to create an equitable environment in which individuals, organizations, and agencies can work together to address an issue of mutual concern which in this case is community and health service delivery. There are several key ingredients to ensure the successful implementation of the model, including a facilitator who will advertise, recruit, and select the community organizations to participate; provide and support a team of staff; and encourage inter and intra-community participation, a host community organization that has good links to the target community, a task that is meaningful, time-limited and manageable. It can be

any or all of the circles in the model diagram, linking communities and agencies in an equitable working relationship, training of community organization members as co-coordinators of the project, Project support worker(s) who provide support to the communities, as directed by the facilitator Community Engagement.

#### **Summary of the model;**

According to the model, communities and agencies work together when they are facilitated, supported, resourced and trained in raising awareness, reducing denial and fear, assessing their needs, capacity building, developing work force, sustaining participation and generating a sense of ownership because equitable services lead to an improved access, experience and outcomes.

This model has been used by the Center for Ethnicity and Health in more than 170 projects, with varying degrees of success (Fountain et al, 2007). However, it was developed in the context of community based research and the communities were financially compensated for participation.

#### **2.2.2 Health Service Delivery Model**

The Health Promotion Model (HPM) The Health Promotion Model described by Pender, Murdaugh and Parsons, (2005) has been revised as a framework since 1996 for planning and research. It has been used particularly for the promotion of healthy lifestyle behaviours including physical activity and eating. The HPM identifies the determinants of health-promoting behaviours as including general individual characteristics and experiences that influence behaviours indirectly, and four behaviour-specific cognitions that affect behaviour specifically (perceived benefits, barriers, self-efficacy and interpersonal influences on behaviour change).

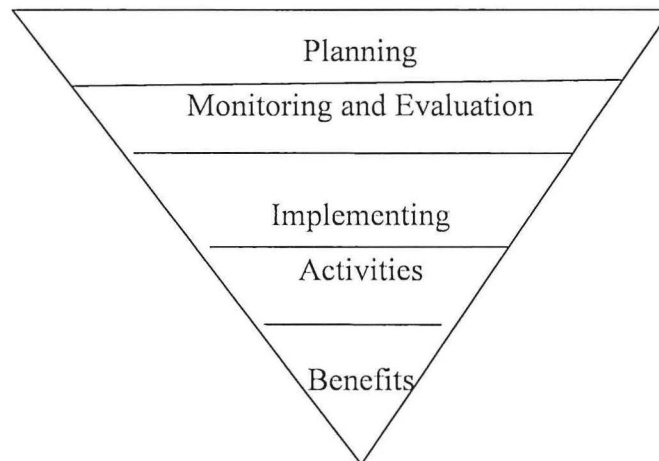
#### **2.3 Participative Decision Making and Health Service Delivery**

Participative decision-making (PDM) in Health Service Delivery is the extent to which Health Service providers engage the Community to share or participate in health service delivery decision making, (Probst, 2005). For some time it has been known that interaction between knowledge producers (community) and users (clinicians, managers, policy-makers) is an influential means by which to generate practice-relevant knowledge and enable evidence-informed practice, (Grimwood 2003). The imperative to improve evidence-informed decision making for improved health care planning, service delivery and evaluation has prompted broader recognition of the need for such partnerships, and the conduct of research on how to optimize researcher-research user collaboration. Now more commonly referred to as integrated knowledge translation, this involves the development of a relationship between partner groups (community)

and decision-makers (Health Service providers) for the purpose of engaging in a mutually beneficial project or program of research (BMC report on Health service, 2014).

### 2.3.1 How people Participate.

**Figure 4: image showing Participation as fan shaped.**



*Source (Dawson S. 2001)*

Dawson (2001) asserts that, Community people are recipients or beneficiaries of health services and education provided by planners and agencies. In many cases, these benefits may demand only their presence at a clinic or a small fee for the services or medicines provided by health staff and/or the government and, thus, their 'passive' participation. Community people participate in activities such as contributing land, labour and money to health programmes. At this level, people who participate in activities do so actively. However, they do not participate in the choice of what activities are to be undertaken and how they will be carried out, as these choices remain in the hands of health planners, agencies or government.

Community people participate in implementing health services by choosing the site of a clinic. At this level, those involved in activities have some managerial responsibilities. They make decisions about how these activities are to be ran, but do not decide which activities are undertaken and how these activities pursue programme objectives because this remains under the control of planners. Community people refer to Health planners for advice, supervision and approval (Dawson S. 2001).

Dawson (2001), further revealed that, People participate in monitoring and evaluation of Health programmes by helping planners judge whether the programme objectives have been met and possibly, if not, why not? At this level community people are involved in deciding how to measure objectives and in monitoring such activities, but are not involved in developing programme objectives. This stage of participation is perhaps the one where there is least experience, in part because in many programmes only lip service is given to monitoring and evaluation and in part because programme objectives, particularly in terms of community participation, are often not clearly articulated and, therefore, cannot be measured. When it come to planning, People from the community (usually leaders and key members such as teachers etc.) actually decide what health programmes they wish to undertake and ask health staff, agencies and/or government to provide the expertise and/or resources to enable the activities to be pursued. This is the level at which community participation is the broadest in both range and depth. It is the articulated ideal for which many programmes strive.

Participative decision making is important where a large number of stakeholders are involved from different walks of life, coming together to make a decision which may benefit everyone. (Omar, 2010). In a participative decision-making process each team member of the community has an opportunity to share their perspectives, voice their ideas on how and what should be done to improve on the health service delivery on for example Child Health, Reproductive Health, Environmmetal Health and sanitation, Health Education and Promotion and Oral Health and Hygiene, Webler, (2002) Communities therefore need to participate in ensuring universal coverage, comprehensiveness, continuity and people-centered health services to improve health outcomes including the health Millennium Development Goals (MDGs).

### **2.3.2 Relevance of participation on Health Service Delivery**

The first Relevance of Participation is that It effects a behaviour change to a state where both elected representatives and administration council officials work with communities to mainly Inform, Consult, Involve, Collaborate and Empower members of the community on issues relating to Maternal and Child Health, Health Education and Promotion, Oral Health and Hygiene and Reproductive Health Care (Donatelle, 2009).

It creates mechanisms, processes and procedures that enable the local community to hold their local government democratically accountable, contribute to policies that are being developed,

and participate in planning and budgetary processes that would better equip the Health sectors to enable better Service Delivery (Donatelle, 2009).

It establishes and sustains an enabling support programme for citizens to take action, mobilize resources and make development happen in their communities. This programme's key actions include conducting Stakeholders Capacity Building Programme with a focus on Community Development, Leadership and Conflict Management Skills, Understanding Your Municipality, Integrated Development Planning, Community Based Planning, Community Participation, Advocacy and Lobbying, Communication, Local Governance and Socio-Economic Rights, and Community Policing (Sebastian, 1998).

#### **2.4 Information Sharing and Health Service Delivery**

This involves gathering information regarding the state of health care in each community, and facilitates interface meetings between community members and health facility staff. During these meetings, information about the state of healthcare is disseminated via a community scorecard and mutual commitments are made to improve services through a joint action plan addressing areas such child Health, maternal mortality Rate, and environmental hygiene by giving reasons for assessment and explaining clearly asking them to share their feelings about their children's health status over time; this helps to build a picture of parent-child attachment over time and the child's attachment and separation behaviour at key stages in their development such as starting school establishing the identities of all adults who care for the child considering parents' views about concerns relating to their parenting (Jones, 2010).

Principles of information sharing according to health Records and Information Privacy Code of Practice (2005)

Clients have a right to respect, Client welfare is paramount in all decision-making about information sharing, Client consent must be obtained wherever possible, prior to sharing client personal information about them, Clients should be made aware of, and have a right to decide, what information is intended to be shared, Under this schedule, client information can only be shared between partner agencies in accordance with privacy legislation requirements, information collected, used and disclosed will be treated confidentially and used only for the purpose for which it was collected (or a directly related purpose).

Relevance of information sharing;

Information sharing is the ultimate recipients of the desirable and undesirable impacts of public policies; and it also encourages engagement in health care decision-making encourages participative democracy, and public accountability (Popay 2010).

## **2.5 Feedback and Health Service Delivery**

Feedback is not simply criticism, constructive or otherwise. Rather, it is a reflection of the perceptions of the person or group providing it. You may think you're presenting things in a particular way, or accomplishing a particular purpose by what you're doing; but if those at whom it's aimed see it differently, you may have little chance of success, or of achieving what you set out to do. (Jacobs 2010).

Importance of feed back in Health Service Delivery.

It gives you tools to improve your program or health project intended for the community. Understanding what's needed and what isn't, and what's working and what isn't helps you to increase the effectiveness and success in service delivery in a given community setting by allowing you to respond to changes in the community, the population, or the situation. There may be social or cultural changes within the population you're working with changes in the community that affect your program for effective health service delivery. Being able to spot and react to these through participant feedback will keep your program current and effective. (Namara 2006)

It can give you information about the history of the community, the history of your health issue in the community, or the history of your population. Hearing from participants that what you're doing has bad connotations in the community, or that it's been tried before, and failed as a result of conditions that haven't changed, can help you create a program without the baggage of past mistakes. (Misra 2007)

It can inform you about personalities and relationships in the community and/or the population you're working with. This kind of knowledge can be very important when you're trying to get different sectors of the community or different neighborhoods working together, or when you're trying to put together a planning or other group in order to deliver a health service. (Jacobs 2009)

### **2.4.2 Challenges related to Feedback**

Using feedback reduces organizational decision-making autonomy and creates challenges, because organizations pressed for resources may not immediately see the benefits.

Lack of resources, including adequate finances and staffing, is the primary challenge many organizations identify in the development of a proactive and interactive feedback process.

Feedback should be shared widely with key stakeholders in the community such as patients, the public, other health care organizations, local authorities and the media, both within and outside your organization (de Luque 2000).

#### **2.4.3 Relevance of feedback to Health Service Delivery.**

Feedback is used to measure performance based on data derived from their routine practice. Health professionals that are keen on receiving feedback usually work towards the betterment of that service. The available evidence suggests that feedback may be effective in improving professional practice depending on how their previous performances have been and whether or not the general community is satisfied with what the Health Service Delivery method or system used. Feedback enabled Health care professionals to modify their clinical practice to better suit the needs of the community at large (Jacobs 2010).

#### **2.5 Summary of literature Review**

The study involved a comprehensive review of background documents, reports and journals on community participation and health service delivery. According to Falleti, T. (2003), the theory of sequential decentralization has three main characteristics; it defines decentralization as a process that takes into account the territorial interests of bargaining actors, and it incorporates policy feedback effects while sequencing of different types of decentralization such as fiscal, administrative, and political.

Two models of community participation came up from the theory that is the Community Participation Health Educator model and Centre for Ethnicity and Health educator model. The CHE model according to Tribe and Labe, (2010) is a three step practical model guide whereby for community participation to be effective, communities should come together, hold focus group discussions in order to identify a problem and construct an intervention program through training of communities and then lay strategies for implementing there after carry out monitoring and evaluation programs. However, with the (CEHM) model according to Fountain et al, (2007), communities and agencies work together when they are affiliated, supported, Resourced, trained, developed which helps to generate a sense of ownership for the intended service or project.

The Health promotion Model (HPM) identifies the determinants of health-promoting behaviours as including general individual characteristics and experiences that influence behaviours indirectly, and four behaviour-specific cognitions that affect behaviour specifically (perceived benefits, barriers, self-efficacy and interpersonal influences on behaviour change).

Participative decision-making (PDM) is the extent to which employers allow or encourage employees to share or participate in health service delivery decision making (Probst, 2005).

Literature also looked at the different ways in which the community can participate in Health Service Delivery which are through Participative decision Making, Information Sharing and through Feedback.

Participative decision-making (PDM) in Health Service Delivery is the extent to which Health Service providers engage the Community to share or participate in health service delivery decision making, (Probst, 2005). The community members participate in various ways such as contributing labour, exchange of ideas, they also help in monitoring and evaluation of programs. Information Sharing involves gathering information regarding the state of health care in each community, and facilitates interface meetings between community members and health facility staff. During these meetings, information about the state of healthcare is disseminated via a community scorecard and mutual commitments are made to improve services through a joint action plan addressing areas such child Health, maternal mortality Rate, and environmental hygiene.

Feedback in Health Service Delivery is not simply criticism, constructive or otherwise. Rather, it is a reflection of the perceptions of the person or group providing it. You may think you're presenting things in a particular way, or accomplishing a particular purpose by what you're doing; but if those at whom it's aimed see it differently, you may have little chance of success, or of achieving what you set out to do (Jacobs 2010).

Using feedback reduces organizational decision-making autonomy and creates challenges, because organizations pressed for resources may not immediately see the benefits. (de Luque 2000).

## CHAPTER THREE

### 3.0 Introduction

This chapter presents the framework of the research and how it was carried out. It covered the research design, geographical area and study population, sampling strategies, data collection techniques, study of variables, data processing and presentation, data analysis and limitations of the study.

### 3.1 Research Design

A qualitative and quantitative research approach alongside the cross sectional survey were chosen for this study. Both qualitative and quantitative approaches were applied since the research findings contained narrative or descriptive and statistical or numerical data respectively. The case study design was in-form of multiple health centers and selected communities due to the fact that the findings were considered more powerful than those from a single health centre and a single community. Whenever the two cases represented two contrasting situations, this was deemed good for comparison of findings. The researcher measured the influence of community participation on service delivery.

### 3.2 Area of Study

The research was carried out in Mukono Municipality which was comprised of two divisions, Goma division and Mukono Central division. The District lies in the Central region of Uganda. The District Headquarters is in Mukono municipality central Division, situated along Kampala-Jinja road (21Kms East of Kampala City).

### 3.3 Population of the Study

The study population was 195 respondents. These consisted of 90 health workers (doctors, nurses, medical assistants, clinic officers and midwives) selected from three Health Centres, (health centre IV, Kyungu health centre III and Mukono Church of Uganda Hospital) and 105 community members living in Kauga village, Nassuti village and Mukono central, but obtaining health services from the three health centers, was chosen as suitable sites for this study because the municipality ranges between extreme urban and extreme rural communities.

### 3.4 Sampling Techniques and Sampling Methods

#### 3.4.1 Sampling techniques

The researcher used both simple random sampling and purposeful sampling techniques

##### 3.4.1.1 Simple Random Sampling

Simple Random Sampling was effective in choosing respondents from a homogeneous population (Nachimias and Nachimias 1981). Each member of the population was assigned a unique number. Each number was placed in or a hat and mixed thoroughly. The blind-folded researcher then picked numbered tags from the hat. All the individuals bearing the numbers picked by the researcher were the subjects for the study. Out of the 2 health centres IVs, 13 Health Centres IIIs and 21 Health Centres IIs, Three health units were chosen at random from the municipality using simple random sampling. Further still, simple random sampling was applied to select community members per homestead, but receiving health services from the different health units in Mukono Municipality. This was done with the guidance of the L.C.1 chairpersons. The researcher held a FGD of 10 households per interval.

##### 3.4.1.2 Purposive sampling

Purpose full sampling was useful when selecting health workers who are the key informants from the health centres based on knowledge and experience they have acquired from handling issues to do with community participation in health service delivery.

#### 3.4.2 Sample Size

Category of Respondent	Health workers		Community members	
	Population	Sample size	Population	Sample size
Mukono Town Council Health Center IV	30	28	35	32
Mukono Church of Uganda Hospital	30	28	35	32
Kyungu Health Centre II	30	28	35	32
<b>TOTAL</b>	<b>90</b>	<b>84</b>	<b>105</b>	<b>96</b>

**Source:** Primary Data

The following formula has been used for sample size determination, (Krejcie & Morgan,1970).

$$\text{Sample size (n)} = \frac{N}{1 + N(e)^2}$$

n = Sample size;      N = Population size;      e = Level of precision (0.05)

For instance, determining sample size (n) for health centre iv;

$$n = \frac{30}{1 + 30(0.05)^2} = \frac{30}{1 + 0.075} = 28$$

### **3.5 Sources of Data**

#### **3.5.1 Primary sources**

Primary data source was collected through first hand information from answered questionnaires and responses obtained from interviews with both the selected community members and health leaders and representatives.

#### **3.5.2 Secondary source**

Secondary data was obtained from Municipal Health Reports - 2014/15, Ministry of Health-Health Sector Strategic Plan III-2010-2015, community participation policy, Children Act 2005 journals, articles, published health reports and newspapers with related to community Participation and Health Service Delivery.

### **3.6 Data Collection Methods and Instruments**

#### **3.6.1 Questionnaires**

Self-administered questionnaire was used in the study (Appendix 1) and all selected health workers from the three health centers was considered. Mugenda (2008) stated that questionnaires are used to obtain vital information about the population and ensure a wide coverage of the population in a short time. In addition Sekaran (2003) states that questionnaires were efficient data collection mechanisms where the researcher knew exactly what was required and how to measure the variables of interest, they were also less expensive and save time and they do not need much skills to administer them. Closed ended questions were used with detailed guiding instructions as regards the way respondents were required to fill them independently with minimal supervision. This was possible because the respondents were literate and were given enough time to fill the questionnaires.

Rensis Likert's scale statement having five category response continuums of 5-1 was used, strongly disagree (1), Disagree (2), Not sure (3), Agree(4), Strongly agree(5) with assertion. In using this each respondent selected a response most suitable to him/her in describing each statement and the response categories were weighed from 5-1 and average for all items was computed accordingly.

Questions formulated were in two sections. Section A captured demographic variables and section B measured the independent variables participative decision making, information sharing and feedback.

The use of questionnaire method was due to the fact that (advantages): It eliminates interview bias and it can be filled with ease at any convenient time and place.

### 3.6.2 Interview guide

Semi structured interview guides were formulated to conduct Face to face interviews between the researcher and the management of the health centers and community members living in Mukono Municipality.

This tool was preferred because (advantages); it would avail the researcher to get information from various sources and it was the most flexible tool.

## 3.7 Data Quality Control (Validity and Reliability)

### 3.7.1 Validity

Validity refers to the extent to which research results can be accurately interpreted & Generated to other populations. Research tools were first prepared, presented to the supervisors who proof read and examined their accuracy. The supervisors' comments were used to improve the questionnaire by eliminating all errors. The researcher ensured that questions were relevant in order to have meaningful and reliable results represented by variables in the study, (Mugenda 2008).

The researcher will use the formula below to establish validity of the research tool;

$$\begin{aligned} \text{Content Validity Index (CVI)} &= \frac{\text{agreed items by all judges as suitable}}{\text{Total number of the items judged}} \\ &= \frac{28}{35} \\ &= \underline{\underline{0.80}} \end{aligned}$$

If the overall content validity Index of the instrument is equal 0.80 which is above the average acceptable index of 0.7 or above for the instrument to be accepted as valid (Amin, 2005).

### 3.7.2 Reliability

Reliability is the measure of the degree to which a research instrument yields consistent results after. Cronbach's Alpha coefficient will be used to measure reliability of the instrument. According to Amin (2005) an alpha of 0.5 or higher is sufficient to show reliability. The closer it is to 1 the higher the internal consistency in reliability, (Sekaran, 2003). Pretesting of questionnaires was also done by administering questionnaires to 10 households within the target communities but outside the sample this helped to identify the gaps and made modifications accordingly.

The questionnaires were pretested using respondents within Mukono Town Council and reliability computed using statistical Package for Social Sciences (SPSS) and scores evaluated.

**Table 3.1: Reliability Statistics**

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	No of Items
.833	.888	35

SOURCE: SPSS output

To ensure reliability of quantitative data, Cronbach’s Alpha Reliability Coefficient for Likert-Type Scales test was performed. In statistics, Cronbach’s alpha is a coefficient of reliability. It is commonly use as a measure of internal consistency or reliability of a psychometric test score for a sample of examinees. According to Sekaran, (2003) some professionals, as a rule of thumb, require a reliability of 0.70 or higher (obtained on a substantial sample) before they use an instrument. Upon performing the test, the results that are above 0.7 are considered reliable.

### 3.8 Data Presentation and Processing

The data collected was edited to find out how respondents answered the questions and if it was in line with due consideration paid to questionnaires sent to the respondents. The data was arranged in groups of similar questions from different questions as answers to be given were unique. This aimed at making the work easier. Percentages and tables were used to quantify items into frequencies to enhance simplicity, presentation and good understanding.

### 3.9 Data Analysis

#### 3.8.1 Quantitative data Analysis

Involved data from the questionnaires only; the data was put in order and structured to get meaning. The raw data was cleaned, sorted and coded. The data coded was entered into the computer, checked and statistically analyzed using the Statistical Package for Social Sciences (SPSS) software package to generate descriptive and inferential Statistics. Descriptive analysis was applied to describe the primary variables and associated indicator item related to the study objectives by generating percentages, mean and standard deviation. The Pearson product correlation coefficient were used to determine the relationship among variables and regression coefficient models were also used to determine the extent to which the community participation impacts on the health service delivery. The results were presented in form of tables and charts then discussed in relation to existing literature, conclusions and recommendations were drawn in relation to the set objectives of the study.

### **3.8.2 Qualitative Data Analysis**

Qualitative data was collected using interview guide during the discussion with the health center managers, community members and documentary review. Descriptive statistics was categorized and organized based on pattern, repetitions and commonalities into different themes and sub-themes using critical judgmental approach and quotations, (Rwomushana, 2005). This kind of data was interpreted by explanations and substantiated using open responses from the field. The data was analyzed based on study variables and information was recorded and summarized.

### **3.10 Limitations and de-limitations of the Study**

Inadequate funds; the researcher faced a challenge of inadequate funds to conduct her study in relation to transportation costs, secretarial costs and communication costs. Early resource mobilization was a way-forward on inadequate funds. The researcher approached her relatives and friends in time, to mobilize financial resources sufficient to enable her conduct her study successfully.

Failure to balance work and Research; the researcher faced a challenge of trying to balance both work and research as both aspects will be very demanding. This was solved by asking for a three months leave without pay.

### **Conclusion**

This chapter attempted to described the detailed methodology, which is the step by step approach that was used to collect detailed data to enhance presentation of findings in the proceeding chapter

## CHAPTER FOUR

### DATA PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

#### 4.0 Introduction

This Chapter gives the description of the background variables, data analysis, presentation and interpretation of the findings. The chapter presents the study findings on the basis of the study objectives. The findings are presented basing on the research questions that sought to investigate the relationship between Community Participation and Health Service Delivery. The study was premised on the following research questions:

- a) To what extent does participative decision making influence health service delivery in Mukono municipality?
- b) What is the relationship between information sharing and health service delivery in Mukono Municipality?
- c) What is the relationship between feedback and health service delivery in Mukono Municipality?

#### 4.1 Response Rate

The response rate is used to explain whether sufficient information was obtained give meaningful conclusion of the data analyzed. Statistics on the actual questionnaires filled and returned were tabulated as follows;

**Table 4.1: Response Rate**

n=180

<b>Instruments Administered</b>	<b>Frequency</b>	<b>Percent</b>
Questionnaires Distributed (Health Workers)	72	100
Questionnaires not returned	00	00
<b>Interviews</b> (councilors, Village Health Teams L.C.I chairpersons)		
Interviewed respondents	26	100
<b>Focus Group Discussion</b> (community members)	82	100
<b>Totals</b>	180	100%

*Source: Primary data*

The researcher administered questionnaires to collect data from 72 Health Workers. These returned 72 questionnaires fully answered thereby providing a response rate of 100% return rate. Face to face interviews were carried out among; 06 councilors, 12 Village health teams, 08 L.C.I

chairpersons within Mukono Municipality. In total 26 respondents were interviewed making a total percentage of 100%. Finally the researcher also conducted focus group discussions with 82 Community members. The overall response rate was 100%. This finding is synonymous to Mugenda (2008), who revealed that a response rate above 70% is very good for the study results to be valid.

## 4.2 Background Information of the Respondents

In order to find out about the demographic data, respondents were asked about their gender, age, educational level and Length of service whose data was presented and analyzed as below;

### 4.2.1 Gender Distribution of the respondents

The study was gender sensitive as illustrated below;

**Table 4.2: Gender Distribution**

		Gender			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	72	40.0	40.0	40.0
	Female	108	60.0	60.0	100.0
	Total	180	100.0	100.0	

**Source:** Primary data

From the above table, it is shown that 72(40%) of the participants were males while 108(60%) were female respondents. The implication of table 4.1 results is that the study involved either sex though with more female respondents, this helped to obtain more objective data about community participation and health service delivery.

### 4.2.2 Age Bracket of the respondents

Question 2 in the questionnaire was used to obtain data on this parameter; as presented in table below;

**Table 4.3: Age bracket of the Respondents**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-29 years	37	20.6	20.6	20.6
	30-39 years	73	40.6	40.6	61.1
	40-49 years	44	24.4	24.4	85.6
	50 years and above	26	14.4	14.4	100.0
	Total	180	100.0	100.0	

**Source:** Primary data

Table 4.3 majority of the respondents 73 (40.6%) were aged between 30-39years because Mukono Municipality had more of the middle age adults, experienced and knowledgeable to handle community participation related issues to influence health service delivery. 44 (24.4 percent) were aged between 40-49years, 37(20.6 percent) were of the age bracket between 20 to 29 while 26(14.4 percent) of the respondents were aged 50years and above. On analysis of the above finding, majority of the age group were between 30-49years, implying that these age bracket was most informed and desired much health awareness strategies for a healthier and durable life span.

#### 4.2.3 Education Level

Question 3 in the questionnaire was used to elicit information on this variable; table 4.4 as demonstrates the finding below;

**Table 4.4: Showing the Education Level of the Respondents**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Certificate and Below	60	33.3	33.3	33.3
Diploma	30	16.7	16.7	50.0
Degree	62	34.4	34.4	84.4
Post Graduate	28	15.6	15.6	100.0
Total	180	100.0	100.0	

*Source: Primary Data*

Table 4.4 above shows that the qualifications of respondents in Mukono municipality as; 60(33.3%) had certificates, 30 (16.7%) were diploma holders, 62 (34.4%) had degrees while 28(15.6%) held Post graduate Qualifications. This implies that most of the respondents were graduates and therefore clearly understood the variables under investigation.

#### 4.2.4 Length of service at Mukono Municipality Health Centre

Data on this parameter was obtained through question 4 in the questionnaire; and below is their feedback.

**Table 4.5: Length of service**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1-3 years	46	25.6	25.6	25.6
4-6 years	72	40.0	40.0	65.6
7 years and above	62	34.4	34.4	100.0
Total	180	100.0	100.0	

*Source: Primary data*

Table 4.4 above illustrates that 25.6 percent of health workers had served for the period between 1-3years, 40 percent had worked for 4 to 6years, 34.4 percent for a period of over 7 years. This indicates that most of the health workers had served between 4 to 7 years and were therefore deemed to have sufficient data about the community participation systems and health delivery processes and procedures.

#### **4.2.5 Periodicity of Community involvement**

**Table 4.6: Length of service**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Annually	46	25.6	25.6	25.6
Semi- Annually	56	31.1	31.1	56.7
Quarterly	44	24.4	24.4	81.1
Monthly	34	18.9	18.9	100.0
Total	180	100.0	100.0	

Table 4.6 above reveals that in Mukono Municipality, 25.6% of the Village health teams and municipality health teams carried out community participation annually, 31.1% conducted community participation on semi annually, 24.4% did it on quarterly basis while 18.9% did it on monthly basis. This means that community participation in health service delivery was low.

#### **4.2.6 Position or Responsibility held**

Question 5 in the questionnaire was used to obtain data on this parameter; Table 4.5 below shows the results;

**Table 4.7: Position of responsibility**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Doctors	15	8.3	8.3	8.3
	Nurses	47	26.1	26.1	34.4
	Midwife	22	12.2	12.2	46.7
	Village Health Teams	14	7.8	7.8	54.4
	Councilors & LCs	15	8.3	8.3	62.8
	Community Members	67	37.2	37.2	100.0
	Total	180	100.0	100.0	

*Source: Primary Data*

Results in Table 4.7 above indicates that 8.3% of the respondents were doctors, 26.1% were nurses, 12.2% were midwives, 7.8% were members of the village health teams, Councilors and LCs comprised of 8.3% of the total respondents while 37.2% were community staff. The implication of table 4.5 findings is that it helps to provide a basis for reliability of data as all categories of respondents who participated in the study worked together in ensuring effective health services among the service providers and the service users.

### **4.3 Participative Decision Making and Health Service Delivery**

The first objective of the study was to Indicate by ticking the extent to which you agree with the following statements. Using the Likert scale: strongly agree (1), agree (2), disagree (3), strongly disagree (4), not sure (5). To elicit data about the objective, the researcher administered research tools whose findings were presented under section 4.3 as follows;

**Table 4.8: Participative in Decision Making and Health Service Delivery**

<b>Descriptive Statistics</b>					
<b>Participative in Decision Making and Health Service Delivery</b>	<b>N</b>	<b>Min</b>	<b>Max</b>	<b>Mean</b>	<b>Std. Deviation</b>
Subordinates are given an opportunity to get provide information on their illnesses affecting their state of health	180	1	5	3.15	1.41
Participatory health planning helps to pursue objectivity in health service delivery	180	1	5	3.59	1.268
At Mukono Municipality, community ideas are valued in deciding health service delivery	180	1	5	3.78	1.36
Ideas generated during the community health meetings set priority for the area	180	1	5	3.79	1.39
I participate in health matters to guide Mukono Municipality make correct health decisions		1	5	3.59	1.26
Community participation allows Coordination of health services at the municipality	180	1	5	3.78	1.36
Community participation enhances Negotiation for priorities	180	1	4	2.56	.814
Community participation enhances Planning for specific areas of responsibility	180	1	4	1.88	1.47
Community participation improves Representation of the interests of my business	180	1	5	2.62	1.43
Participation enhances quality of services make staff accountable for results	180	1	5	2.79	1.55
I participate in decision making to influence the goals of health centers	180	1	5	3.11	1.33
I participate in planning to exchange information for Mukono Municipality decision making	180	1	4	2.33	1.22
With community participation budgeting, quality and efficiency of health services is realized	180	1	5	1.92	1.40
Community Participation improves management of programmes and ensures optimum use of funds as well as quality of health service delivered	180	1	5	3.62	1.31
Encourages Health education and promotion	180	1	5	3.08	1.48

Respondents generally agreed that Subordinates are given an opportunity to get/ provide information on the illnesses affecting their state of health (mean =3.1512 and  $\sigma = 1.41019$ ). The study shows that Participatory health planning helps to pursue objectivity in health service

delivery (mean=3.5930 and  $\sigma = 1.26842$ ). It was further found out that at Mukono Municipality, community ideas are valued in deciding health service delivery (mean =3.7791 and  $\sigma = 1.36684$ ). The study shows that Ideas generated during the community health meetings set priority for the area (mean= 3.7907 and  $\sigma = 1.39846$ ). It was further found out that participation in health matters to guide Mukono Municipality make correct health decisions. Respondents generally agreed that Community participation allows Coordination of health services at the municipality (mean=3.5930 and  $\sigma = 1.26842$ ). Respondents generally agreed that community participation enhances negotiation for priorities (mean =3.7791 and  $\sigma=1.36684$ ).

The overall mean was 21.6861 and standard deviation =8.07917. This implies that Participation in decision making affects the performance of Health Service Delivery at Mukono Municipality. The respondents agreed that Community participation enhances Planning for specific areas of responsibility. Item means of 3.7791 and standard deviations of 1.36684. The respondents were asked whether Community participation improves Representation of the interests of my business. Item means of 3.5930 and standard deviations of 1.26842. When the researcher interviewed one of the members of staff she had this to say.

*“When the Village Health Committees are requested by the health facility to select people to be trained as community health workers, there are always complaints from community members as to why they have not been considered. However when it comes to performing menial work like fetching water, mounding building blocks or cleaning the surroundings, very few people are willing to volunteer.”*

The respondents were asked whether Participation enhances quality of services make staff accountable for results. Item means of 3.7907 and standard deviations of 1.39846 measuring a level of agreement were computed from the respondents’ responses one of the key informants said,

Another staff member said; *“Even after distributing mosquito nets to pregnant women, some of the recipients do not use them because they say they feel uncomfortable to sleep under an Insecticide Treated Mosquito Net (ITMN).”*

*“Even when we tell households to come and get bottles of chlorine every month, most of them do not come. They just like rushing to us when they are sick to ask for help.”*

The chairperson of Kauga Village Health Committee put it this way during an interview held on 3<sup>rd</sup> September, 2015:

*“When we go round the villages, we still find a lot of households with dirty surroundings. Some households do not have toilets despite the VHC having taught them about hygiene and sanitation. When asked why they do not have toilets, they give unnecessary excuses like, we were busy at the fields or we were thinking about doing that tomorrow. Even when we go back for inspections after three months, we still find the same situation and we are given the same excuses.”*

The respondents were asked whether the most commonly cited reasons for participation in decision making influences the goals of health centers. Item means of 3.7791 and standard deviations of 1.36684 measuring a level of agreement were computed from the respondents' responses

Table 4.8 above illustrates that, I participate in decision making to influence the goals of health centers, (with mean=1.88,  $\delta = .662$  ). This implies that,

Respondents supported the view that, I participate in planning to exchange information for Mukono Municipality decision making (with mean=2.62,  $\delta = 1.465$ ).

The respondents supported the view that, with community participation budgeting, quality and efficiency of health services is realized (with mean=2.79,  $\delta = 1.431$  ). On analysis of the findings,

Respondents supported the view that, (with mean=3.11,  $\delta = 1.55$ ) staff at Community Participation improves management of programmes and ensures optimum use of funds as well as quality of health service delivered. On analysis of table 4.6 findings, community participation envisioned self-motivated individuals and communities working together with the state to design their own health programmes and improve health development. Individuals and families would come to view health not only as a right, but a responsibility. Individuals and communities would therefore be involved in assessment of situation, definition of (health) problems and setting of priorities as well as help in planning health activities and subsequently cooperate when these activities are carried out.

The study result in Table 4.6 shows that, Encourages Health education and promotion (with mean=2.33  $\delta = 1.328$ ). This means that, community participation, as a medium for successful primary health care services, is an essential cog in the wheel of ensuring that community

programmes and projects are well thought out, executed, monitored, evaluated, maintained, managed and sustained for this generation and posterity.

**Table 4.9: Correlation for participation in decision making and health service delivery in Mukono municipality**

Bivariate analysis

<b>Correlations</b>			
		<b>Participation in decision making</b>	<b>health service delivery</b>
<b>Participation in decision making</b>	Pearson Correlation	1	.883**
	Sig. (2-tailed)		.000
	N	195	195
<b>Health Service Delivery</b>	Pearson Correlation	.883**	1
	Sig. (2-tailed)	.000	
	N	195	195
**. Correlation is significant at the 0.01 level (2-tailed).			

The results show that the correlation coefficient is 0.883(\*\*) and its significance level 0.00. Therefore according to the results, there is a positive significant relationship ( $r = .883$ ;  $p < 0.01$ ) between participation in decision making and health service delivery in Mukono Municipality. This implies that allowing community members to participate in decision making in regard their health requirements permits them to suggest the kind of health needs to access and receive which helps to improved health service by 78% (obtained from the  $r^2$  value). This aids policy makers to take decisions on the kind of health services suitable for citizens of Mukono Municipality.

#### 4.4 Information Sharing and Health Service Delivery in Mukono Municipality

In bid to establish, the results to the second objective of the study which was to *examine the effect of information sharing and health service delivery in Mukono Municipality*; respondents indicated the extent to which they strongly agree (5), agree(4), disagree(3), strongly disagree (2) and not sure (1) as presented in the table below;

**Table 4.10: information sharing and health service delivery in Mukono Municipality**

information sharing and health service delivery	N	Minimum	Maximum	Mean	Std. Deviation
Improves health awareness and prevention of sexually transmitted infections	180	1	5	3.0698	1.40412
Aids decision as to whether to use condoms, Abstinence, remain faithful to a partner, have Regular STI tests for quality of health services	180	1	5	3.6163	1.29405
Reduces self-medication dangers	180	1	5	3.7907	1.36439
Improves community mobilization about killer diseases	180	1	5	3.7674	1.36057
Reduces malnutrition among children	180	1	5	3.7674	1.36057
Increase cordial relationship among health workers and patients	180	1	5	3.6163	1.29405
Improves coordination among health workers and the community	180	1	5	3.7907	1.36439
Allows Prevention of Mother To Child Transmission	180	1	5	3.7791	1.36684
Both husband and wife being involved with the wife in family planning	180	1	5	3.9302	1.43724
Controls Social stigma & fatigue	180	1	5	3.6047	1.32202
Permits health workers and mothers to share Antenatal care or postnatal care information	180	1	5	3.7674	1.36057
Allows sexual discussions	180	1	5	3.7674	1.36057
Information sharing allows learning family responsibility	180	1	5	3.7674	1.36057
Allows decisions in using contraceptives	180	1	5	2.331	1.527
Positive attitude of health workers towards Supportive services	180	1	5	2.85	1.721

*Source: Primary data*

The respondents were asked whether information sharing improves health awareness and prevention of sexually transmitted infections. Item means of 3.0698 and standard deviations of 1.40412 measuring a level of agreement were computed from the respondents' responses.

The respondents were asked whether information sharing Aids decision as to whether to use condoms, Abstinence, remain faithful to a partner, have Regular STI tests for quality of health services. Item means of 3.6163 and standard deviations of 1.29405 measuring a level of agreement were computed from the respondents' responses.

Respondents generally agreed that information sharing reduces self-medication dangers (mean= 3.7791 and  $\sigma = 1.36684$ ). The study shows that information sharing Improves community mobilization about killer diseases (mean= 3.9302 and  $\sigma = 1.43724$ ). It was further found out that information sharing Reduces malnutrition among children (mean=3.6047 and  $\sigma = 1.32202$ ).

Respondents generally agreed that information sharing Increase cordial relationship among health workers and patients (mean=3.7674 and  $\sigma = 1.36057$ ). The study shows that I information sharing Improves coordination among health workers and the community (mean= 3.7674 and  $\sigma = 1.36057$ ). It was further found out that S information sharing Allows Prevention of Mother to Child Transmission (mean= 3.7674 and  $\sigma = 1.36057$ ).

The respondents supported the view that, information sharing aids both husband and wife to participate and consent in family planning (with mean=1.92,  $\delta = 121$ ).

The respondents supported the view that, (with mean=3.62,  $\delta = 1.401$ ) information sharing Controls Social stigma & fatigue. On analysis of table 4.10 findings, Poor performance of service providers leads to inaccessibility of care and inappropriate care, which thus contribute to reduced health outcomes as people are not using services or are mistreated due to harmful practices.

Table 4.10 illustrates that information sharing Permits health workers and mothers to share Antenatal care or postnatal care information (with mean=2.08,  $\sigma = 1.305$ ). On analysis of this finding, providing an individual with adequate and reliable information about treatment options; billing or debt-recovery (with care and discretion, consistent with confidentiality); a provider's management, funding, complaint-handling, planning, evaluation and accreditation activities (for example, activities aids clients to assess the cost effectiveness of a particular treatment or service); disclosure to a medical expert (only for medico-legal opinion), an insurer, a medical defence organisation, or a lawyer, solely for the purpose of addressing liability indemnity arrangements (such as reporting an adverse incident), or for the defence of anticipated or existing legal proceedings; an organisation's quality assurance or clinical audit activities, where they

evaluate and seek to improve the delivery of a particular treatment or service; and disclosure to a clinical supervisor by a psychiatrist, psychologist or social worker.

Respondents sustained the view that, information sharing Allows sexual discussions (with mean=3.52  $\delta = 1.33$ ). This means that Appropriate, timely sharing of vital patient information can better inform decision making at the point of care and allow providers to; Avoid readmissions, Avoid medication errors, Improve diagnoses and Decrease duplicate testing.

Table 4.10 indicate that, the respondents concurred that Information sharing allows learning family responsibility (with mean=2.59,  $\delta = 1.488$ ). This means that community members paid less attention to family responsibilities because of limited family information sharing.

The study revealed that information sharing Allows decisions in using contraceptives. The implication of the above finding is that, (with mean=3.08  $\delta = 1.481$ ). This meant that Information governance is about managing information for the benefit of patients, and the quality of that information is just as important for their care and for the funding of organisations (where payment for patient care is dependent on the accuracy of information collected on the number and type of procedures carried out) as the systems that manage it.

Further still the study revealed that information sharing Positive attitude of health workers towards Supportive services (with mean=3.08,  $\delta = 1.481$ ). This implies that supportive supervision, training and improving leadership and management create a positive attitude and motivation to work.

One key informant, “said disruptions with service provision also occurred at health facilities when the nurse went to town or was out for a funeral or family problem”. This is because there was usually no one to sit in for her in such situations except for the cleaner and when people went to the clinic, they were told to go to other health facilities or come when the nurse was around. Satisfaction with the quality services provided at health facilities affect access to health services in Mukono Municipality. Client-perceived quality of services and confidence in the health provider also affected the health service utilisation.

**Table 4. 11: Correlation for information sharing and health service delivery**

<b>Correlations</b>			
		<b>Information sharing</b>	<b>Health Service Delivery</b>
<b>Information sharing</b>	Pearson Correlation	1	.925*
	Sig. (2-tailed)		.000
	N	195	195
<b>health service delivery</b>	Pearson Correlation	.925*	1
	Sig. (2-tailed)	.000	
	N	195	195

\*\* . Correlation is significant at the 0.01 level (2-tailed).

**Source: Primary data**

**Source: Primary data**

The relationship between information sharing and health service delivery is statistically significant since .011 is less than 0.05(95% confidence level). The table shows that there is a positive relationship between information sharing and health service delivery because the two variables are moving in the same direction (Pearson (r)= .925\*\*) sig value P(value) being 0.01>.000, N is the sample size (195) with a sig value .000 meaning that the relationship between information sharing and health service delivery is statistically significant since .000 is less than 0.05(95% confidence level). This would imply that as information sharing improves, health service delivery is strongly enhanced therefore information sharing community health through effective health service delivery.

Lack of information about health issues perpetuated stigma, discrimination as well as myths and misconceptions about certain illnesses and health services.

Participants in Focus Group Discussions noted that the level of stigma and discrimination among people living with HIV/AIDS were still high among people in Mukono Municipality due to lack of adequate information on HIV/AIDS. This lack of information resulted in stigma against those infected and consequently those already infected were not able to disclose their HIV status for fear of isolation and discrimination. HIV was reported to be a reason for divorce, as some key informants mentioned cases of marital separation where a spouse was found to be HIV/AIDS positive. Fear of stigma and discrimination also prevented people from seeking health services such as counseling and testing due to fear of being isolated following disclosure of their status.

It was suggested by key informants that there was also need for more education and awareness raising in communities in order to increase access to health services such as family planning and Antiretroviral Therapy (ART) as some women in the communities avoid taking family planning pills because of the belief that anyone who took such drugs would never be able to have children as the medicines led to infertility in women. There were also misconceptions about the side effects of family planning drugs and ARV in communities which made people uncomfortable to utilise these services. Lack of information on health issues among members of the community led to delays in seeking care at health facilities. It was observed that some patients only went to the clinic when their illness was well advanced and other patients did not go for post disease checkup. This was largely due to people not having much education about health issues; this made it difficult for them to identify signs of illness which require them to seek medical attention at the clinic. Furthermore, lack of information on health issues perpetuated myths, misconceptions, norms, values and beliefs which are impediments to accessing health care at health facilities.

#### 4.5 Feedback and Health Service Delivery in Mukono Municipality

In bid to elicit data about the effect of feedback lead and health service delivery in mukono municipality as the third objective of the study, the researcher administered research tools whose responses are as follows;

**Table 4. 12: The effect of feedback lead on health service delivery in Mukono Municipality**

feedback and health service delivery in mukono municipality	N	Minimum	maximum	Mean	Standard Deviation
Increases the number of times a pregnant woman attends ANC	180	1	5	2.79	1.431
Aids to review the quality of information, enable programmed child spacing	180	1	5	3.11	1.550
Social contact and interpersonal support influence Individual/couple decisions on health matters (e.g. when to have children, number of children)	180	1	5	2.33	1.328
Positive feedback enhance attitude & knowledge towards positive health living	180	1	5	1.92	1.219
feedback improves maternal and child health care services	180	1	5	3.62	1.401
Feedback on delivery and postnatal care and baby enhance health living	180	1	5	2.08	1.305
Feedback allows Treatment of ailments and review of treatment	180	1	5	2.85	1.721
Feedback about family planning methods reduces cancer	180	1	5	2.29	1.527
Feedback makes Mukono community knowledgeable about sexual matters	180	1	5	4.09	1.454
Feedback enhances williness to undertake preventive measures against STIs	180	1	5	2.77	1.596
Care provided to a pregnant mother at delivery can be reviewed by during pregnancy and after delivery	180	1	5	3.42	1.458
Feedback allows being free with the health workers at the ANC clinic	180	1	5	3.55	1.459
Feedback on health workers welcoming , Rudeness & Disrespect enhances better health services	180	1	5	2.79	1.431
Feedback promotes positive feeling towards discussing family planning	180	1	5	3.11	1.550
Abnormal fetus development, Complicated delivery, Loss of pregnancy or death	180	1	5	3.06	

*Source: Primary data*

Table above shows that feedback Increases the number of times a pregnant woman attends ANC (with mean=2.79,  $\delta = 1.431$ ). On analysis of table 4.12 findings, Patient feedback inform did

not help to evaluate health needs assessment, measure patient experience, perceived health status and outcomes of care.

Table 4.12 above shows that Aids to review the quality of information, enable programmed child spacing (with mean  $3.11 = 1.550$ ) . This means that pregnant mothers did not obtain sufficient information in regard to child birth associated with increased risk of: Low birth weight, Small size for gestational age and Preterm birth. Some experts believe that closely spaced pregnancies don't give a mother enough time to recover from the physical stress of one pregnancy before moving on to the next. However, it's also possible that behavioral risk factors, such as failure to use health care services, unplanned pregnancies, stress and socio-economic disadvantage, are more common in women who have closely spaced pregnancies. These risk factors-rather than the short interval itself-might explain the link between closely spaced pregnancies and health problems for mothers and babies.

Table 4.12 above shows that social contact and interpersonal support influence Individual/couple decisions on health matters (e.g. when to have children, number of children) (with mean= $2.33$ ,  $\delta = 1.328$ ). This means that Decision making in whatever context is a complex issue and gender is generally regarded as one of the power sources in reproductive decision making. The decision making process among HIV-positive couples revealed that decision making is not straightforward as people do not always have similar desires or methods with which to attain those desires. The decisions made by these couples were a result of negotiation and compromise. Although there were differences of opinion and disagreements, the couples indicated that they were able to make collaborative decisions.

Table 4.12 above that Positive feedback enhance attitude & knowledge towards positive health living (with mean= $1.92$ ,  $\delta = 1.219$ ). This meant that feedback determined fertility and sexual preferences of women tended to determine the couple's decisions on reproduction and contraception. In couples where the men intended to have a child now or in the near future and the woman did not want to have a child.

From Table 4.12 above shows that Feedback on delivery and postnatal care and baby enhance health living (with mean= $3.62$ ,  $\delta = 1.401$ ). On analysis of this finding, it is the norm for the husband or the man to determine or dominate decisions regarding child bearing. It is regarded as conventional wisdom that men dominate reproductive decision making.

Table 4.12 above shows stated Feedback allows Treatment of ailments and review of treatment (with mean=2.08,  $\delta = 1.401$ ). This means that Patients tend to be more satisfied if a doctor takes an holistic approach, feeling that their doctor has time for them and their problems which was not the case.

Table 4.12 reveals that the respondents stated Feedback about family planning methods reduces cancer (with mean=, 2.29  $\delta = 1.529$ ). The implication of the above finding is that, there was accelerated breast cancer as an absolute risk due to limited feedback.

Findings in Table 4.12 illustrate that, Feedback makes Mukono community knowledgeable about sexual matters (with mean=4.09,  $\delta = 1.454$ ). The implication of the finding is that, community members in Mukono municipality were sensitized sufficiently about the effect of HIV on their health and hence this reduced the infection rate as well as the death rate.

Table 4.12 findings indicated that, feedback enhances willing to undertake preventive measures against STIs (mean=2.115,  $\delta = 1.454$ ). On analysis of the findings, Mukono municipality members willingly undertake safety measures against HIV infection as a result of feedback.

Table 4.12 shows that, Care provided to a pregnant mother at delivery can be reviewed during pregnancy and after delivery (with mean=2.77,  $\delta = 1.596$ ). This means that health workers did not reach their clients consult their clients to receive feedback. Table 4.10 shows that, feedback allows being free with the health workers at the ANC clinic (with mean=3.42,  $\delta = 1.459$ ). The implication of the above finding is that, majority of health workers in Mukono municipality health centers and Village Health Teams paid special attention.

The study indicated in Table 4.12 that, feedback on health workers welcoming, Rudeness & Disrespect enhances better health services, (mean = 1.431, SD=1.43). This means that health practitioners did not attend to their clients perfectly. This negative feedback attributed to unhealthy relationships towards discussing client's health status.

The results as reflected from Table 4.12 confirms that, Abnormal fetus development, Complicated delivery, Loss of pregnancy or death (with mean=,3.11  $\delta$  = 1.550). This was due to poor feedback from health practitioners.

**Table 4. 13: Relationship between feedback led and health service delivery in Mukono municipality**

		<b>Correlations</b>	
		Feedback	Health Service Delivery
Feedback	Pearson Correlation	1	.052
	Sig. (2-tailed)		.730
	N	195	195
Health Service Delivery	Pearson Correlation	.052	1
	Sig. (2-tailed)	.730	
	N	195	195

\*. Correlation is significant at the 0.05 level (2-tailed).

From Table 4.13, there is a relationship between feedback and health service delivery in Mukono Municipality in Mukono Municipality ( $r = .052$ ;  $p = 0.73$  and  $> 0.05$ ). The study results therefore show that the feedback has a positive relationship on health service delivery. Since the Pearson correlation coefficient 0.52 is significant at 0.000 being less than 0.05 (alpha level), there is a positive relation between feedback lead and health service delivery in Mukono Municipality.

This explains that there is a weak correlation co-efficient between the two variables which is 0.052 which is explained by the feedback which make health service delivery difficult for the health centres to reach their clients.

## 4.6 Regression analysis

### 4.6.1 Multiple Ordinary least squares Regression Analysis

The results in the table 4.14 below show the multiple ordinary least squares regression model. This was presented for the purpose of addressing the third objective for the combined effect of three predictor variables (Participative Decision Making, Information Sharing and Feedback) on the dependent variable outreach.

**Table 4. 14: Regression Analysis**

Model	<i>Unstandardized Coefficients</i>		<i>Standardized Coefficients</i>	t	Sig.
	B	Std. Error	Beta		
(Constant)	1.172	.664		1.765	.087
Participative Decision Making	.326	.152	.339	2.143	.040
Information Sharing	.260	.119	.345	2.184	.037
Feedback	.458	.194	.398	2.197	.056
Dependent Variable: health service delivery					
R	.81				
R Square	.65				
Adjusted R Square	.625				
F Statistic	7.002				
Sig.	.003				

*a. Predictors: (Constant), Participative Decision Making, Information Sharing & Feedback*

**Source:** Primary data

The table above shows that predictor variables of community participation (Participative Decision Making ( $P_{dm}$ ), Information Sharing ( $I_s$ ) & Feedback( $F$ ) explain 62.5% of variations in health service delivery. Results show a significant model ( $F=7.002$ ,  $sig=0.003$ ) to explain a multi regression equation of health service delivery ( $y$ ) =  $1.172+0.326(P_{dm}) +0.260(I_s) +0.458F$

The three predictors cause 62.5% variations in health service delivery at a coefficient of multiple determination ( $R^2 = .625$ ). Thus the regression output ( $R=0.81$ ) suggest if community Participative Decision Making, Information Sharing & Feedback are well managed, they should significantly improve health service delivery at health centres of Mukono Municipality.

Further still, table 4.14 above shows that with a unit change of the independent variables community participation (Participative Decision Making, Information Sharing & Feedback) results in 94% dependent variable (Health Service Delivery). This shows that the effect is significant and greatly affects the dependent variable Health Service Delivery. This implies that health centers have to uphold Participative Decision Making, Information Sharing & Feedback so as to influence the level of quality health services among the communities.

### **Conclusion**

Chapter four results were presented, analyzed and interpreted carefully using statistical methods (Special Package for Social Sciences-SPSS) in context with the study objectives. Regression analysis indicated that community participation was influenced by participation in decision making, information sharing and consistent feedback to create impact on health service delivery. This therefore provided a backbone for the next.

## CHAPTER FIVE

### DISCUSSION, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 5.0 Introduction

This chapter explores discussion of the major findings, a summary of the findings, conclusions, recommendations drawn there after based on previous chapter and answering the objectives of the study spelt out in chapter one.

#### 5.1 Discussion of the Major findings

##### 5.1.1 Participative decision making on health service delivery

The results show that the correlation coefficient (Pearson (r)= .883; sig value P(value)  $P < 0.05=000$ . This implied that Community participation in health care enables members of the community either individually or collectively to assume greater responsibility for their health needs and problems. Community members in Mukono Municipality participate in budgeting for health care activities in the Municipality. Every year Neighborhood Health Committees (VHT) identify activities which they want to undertake and these are submitted to Mukono Municipality Health Management Team (MMHMT). After the community action plans have been submitted to MMHMT, VHT are then given budget ceiling for their action plans which they use as a guide in budgeting for community health activities.

At the health facility level, community representatives (Chairpersons of VHT) also take part in formulating the budget for the health center or health post as members of the Health Center Committees. Some health facilities had trained some community members as malaria agents. The malaria agents were providing Rapid Diagnosis Testing (RDT) to people in their communities, administer malaria drugs, distribute Insecticide Treated Mosquito Nets (ITMNs) and conducting sensitisations on malaria prevention. Further still one of the health facilities had trained some community members as HIV/AIDS counselors. The counselors were providing HIV/AIDS counseling in their community and at the health facility on days when the health facilities were providing HIV/AIDS counseling. 25% of the respondents identified health facilities had trained some community members as nutrition advisors. The nutrition advisors were involved in teaching mothers in their communities about nutrition. They were also providing their services to mothers at the health facilities who went for under 5. 60% of the respondents identified health facilities had trained community members to provide Direct Observation Treatment (DOT) to

tuberculosis (TB) patients in their communities. TB treatment supporters were working as adherence counselors to patients on TB treatment. They were also conducting sensitisation on TB to people in their community. The results correspond to Rifkin (1996), who revealed that the expected outcomes of community participation in the health services include more health consciousness which pushes up the demand, more access to health care through community-level workers and improvement of community level health infrastructure. 30% of the respondents identified health facilities had trained some community members as growth promoters. Growth promoters were conducting sensitisation on how to monitor the growth of children, advising mothers on how to prevent illnesses in children and how to notice signs of ill health.

15% of the respondents identified health facilities had trained community members in Integrated Management of Child Illnesses (IMCI). Those trained were providing diagnosis and treating all the major illnesses in children. They were also attending to children at clinics during Under 5 besides providing services to children in the community.

70% of the respondents identified health facilities had trained some community members in Home Based Care. Those trained were working as caregivers who looked after HIV/AIDS patients and other patients who were not able to take care of themselves. They were also sensitising people in the community on HIV/AIDS prevention, treatment and support.

55% of the respondents identified health facilities had trained some community members as traditional birth attendants (TBAs). Those trained were helping expectant mothers to deliver.

30% of the respondents identified health facilities had trained some community members in safe motherhood. Those trained were mobilising pregnant women in their communities to access antenatal services at health facilities. They were also sensitising pregnant women on danger signs during pregnancy. The study also found out that the community in Mukono Municipality participates in construction of health facilities by providing labour, building materials and transport.

20% of the respondents of health facilities identified in this study were built by Non-Governmental Organisations (NGOs) in partnership with the community. The communities provided 25% of the total project cost while the donor, Christian Children Fund (CCF)

contributed 75%. The community in Mukono Municipality participates in primary health care delivery through planning of community health activities, management of health facilities, construction of health facilities and provision of health services as community health workers. The finding is similar to Peter et al, (2007), who established that Participation is that affects a behaviour change to a state where both elected representatives and administration council officials work with communities to mainly Inform, Consult, Involve, Collaborate and Empower members of the community on issues relating to Maternal and Child Health, Health Education and Promotion, Oral Health and Hygiene and Reproductive Health Care. Health officials worked with communities to mainly Inform, Consult, Involve, Collaborate and Empower members of the community on issues relating to Maternal and Child Health, Health Education and Promotion, Oral Health and Hygiene and Reproductive Health Care.

However, there were very few communities which had community health workers in Mukono Municipality as most of the identified health facilities said they did not have money to train more community health workers. Furthermore, the available community health workers worked as volunteers and were not paid anything for their work. This discouraged a lot of people from continuing with their voluntary work. There were other negative incentives which community health workers faced such as shortages of drug kits and lack of transport. The study found out that there are decentralised structures of health care management in Mukono Municipality known as Neighborhood Health Committees (VHT).

All the identified health facilities serviced specific catchment areas and within a catchment area there were several neighborhood health committees (VHT) who worked hand in hand with health facilities. At the health facility level, each health center or health post has a Health Center Committee (HCC) which is made up of all the Chairpersons of VHT in the catchment area serviced by the health facility. During the annual planning process for the Municipality, VHT, who are representatives of the community, meet with members of the community to review experiences, determine priorities and to agree on community actions.

Community representatives thereafter meet with staff at the health facility to draft community action plans. The community action plans are then submitted to Municipality Health Team (MHMT) for inclusion into the district action plan which is later submitted to the Ministry of Health through the Provincial Health Office, Government of the Republic of Uganda (2010).

Communities in Mukono Municipality participated in the day to day management of health facilities through their elected representatives who are Chairpersons of the Neighborhood Health Committees (VHT). Chairpersons of VHT are members of the Health Center Committees (HCCs). The HCCs were responsible for managing the operations of health facilities. The finding of the study revealed that members of the community participated in the provision of health services as community health workers.

The above finding is supplementary to Probst, (2005), who revealed that, Participative decision-making (PDM) is the extent to which employers allow or encourage employees to share or participate in health service delivery decision making. Further still Grimwood (2003), supported that for some time it has been known that interaction between knowledge producers (community) and users (clinicians, managers, policy-makers) is an influential means by which to generate practice-relevant knowledge and enable evidence-informed practice.

Participants during focus group discussions said they were only called for meetings by the VHT if there was work at the clinic or monetary contributions which the VHT wanted community members to make. Even when community members were requested to make monetary contributions by VHT, they were not told how much money the NHC wanted to raise.

One male participant at a Focus Group Discussion in Mukono Town Council Health Center IV held on 1<sup>st</sup> September 2015 had this to say, “These people (NHC members) are not known by the majority of community members because they rarely call for meetings.” When community members were asked if they were told about the money allocated to community activities by Mukono Municipality Health Management Team (MMHMT) in the annual budget, most participants in Focus Group Discussions said they did not know anything about budgetary allocations as none of them could ever remember being called to a meeting to talk about the budget for community health activities. Most participants thought it was not for the community to decide on what they wanted to do and how much money they needed, they thought the community was there to follow what was said at the clinic. Other participants said although community members were not called for regular meetings by VHT or involved in issues to do the planning for health services and budgeting, they said VHT had done a good job in teaching them about how to prevent diseases. “We have been taught how to keep our surroundings clean by slashing long grass and covering stagnant water with soil so that we can protect ourselves and children from malaria.” (Views of a male participant at a Focus Group Discussion in Mukono

Church of Uganda Hospital held on 9th September, 2015). Other participants also said everyone in their village now knew about malaria and the importance of using insecticide treated mosquito nets. Another participant represented the views of the majority when she said: “We now know about putting chlorine to drinking water in order to prevent diarrhea and cholera. If you do not have chlorine you can even boil your drinking water to kill germs.”(Views of a female participant at a Focus Group Discussion in Mukono Church of Uganda Hospital held on 9th September, 2015).

Key informants further explained that in most villages there were Non- Governmental Organisations who were sensitising the communities on various health issues such as personal hygiene, child health, nutrition, HIV/AIDS, malaria, TB, cholera, diarrhea and other health issues. A lot of people were being availed with information on health through community outreach programs. While most people were aware of the decentralized structures of community participation in health care delivery in Mukono Municipality, 64% respondents said they did not know member of their Village Health Committee (VHC) and how they came to occupy their positions. The people at the grass roots were also not informed of issues of budgetary allocation to community activities as VHT rarely held meetings. However, communities are supposed to hold elections every year to elect members of their VHT. It was revealed that most VHT had never held elections from the time they were formed. Furthermore, most people did not know much about the roles and responsibilities of VHT. The identified weaknesses with VHT in Mukono Municipality excluded the majority of people from taking part in decision making concerning the delivery of health care. Most people in the communities were knowledgeable about how to prevent illnesses at household and community levels in view of the sensitization they were receiving although most of the awareness raising which was done in the communities was in the area of HIV/AIDS, hygiene, malaria and diarrhea.

#### Attitudes of Community Members towards Participation in Primary Health Care;

The study found out that the attitude of community members towards participation in health care varied depending on the level of participation being sought. It was found that community members were more willing to contribute their labor to health projects as well as to be trained as community health workers. During Focus Group Discussions a lot of community members expressed willing to be trained as community based volunteers. Key informants mentioned that it was prestigious to be a community health worker and to be approached by people in the

community for help. The chairperson on the Nabuuti Village Health Committee had this to say during an interview held on 20th September, 2015:

*“When the Village Health Committees are requested by the health facility to select people to be trained as community health workers, there are always complaints from community members as to why they have not been considered. However when it comes to performing menial work like fetching water, mounding building blocks or cleaning the surroundings, very few people are willing to volunteer.”*

It was also revealed that community members were not good at attending meetings to discuss health issues, when meetings were called very few people went and this had forced VHT to abandon the idea of calling for regular meetings. When VHT had urgent information they just informed a few people who were in turn requested to inform their neighbors. It was also explained by some key informants that sometimes community members were not willing to participate in health projects because they thought government had already provided the money. There were times when the Health Centre Committees (HCCs) identified problems at the health facility and requested the community to make contributions, community members were usually skeptical as they tended to think someone wanted to steal their money even when they were able to see the need for such a project. In the same vein, a female participant at a Focus Group Discussion in Kauga Village held on 3rd September, 2015 put it this way:

*“The community does not see any sense in participating in projects because they tend to feel that they were not involved right from the beginning. They are also not sure of the benefits of participating in such activities, especially if they had a bad experience from their previous contributions. Sometimes they believe that donors or government have given money for everything.”*

At household level, it was found that individuals were still not able to participate in health care by safeguarding their own health. A female member of Kauga Village Health Committee had this to say during an interview held on 5<sup>th</sup> September, 2015:

*“Even after distributing mosquito nets to pregnant women, some of the recipients do not use them because they say they feel uncomfortable to sleep under an Insecticide Treated Mosquito Net (ITMN).”*

Some members of the Village Health Committees (VHT) who were interviewed complained that some people did not use the chlorine which they distributed for free to households because they

did not like the test of chlorine. With regards to participation by individuals in improving their health at household level, a male member of Kauga Village Health Committee represented the views of the majority during an interview held on 20th September, 2015 when he said:

*“Even when we tell households to come and get bottles of chlorine every month, most of them do not come. They just like rushing to us when they are sick to ask for help.”*

The chairperson of Kauga Village Health Committee put it this way during an interview held on 3<sup>rd</sup> September, 2015:

*“When we go round the villages, we still find a lot of households with dirty surroundings. Some households do not have toilets despite the VHC having taught them about hygiene and sanitation. When asked why they do not have toilets, they give unnecessary excuses like, we were busy at the fields or we were thinking about doing that tomorrow. Even when we go back for inspections after three months, we still find the same situation and we are given the same excuses.”*

Although most community members were knowledgeable about how to prevent diseases at individual or household level, there were negative attitudes among community members towards adhering to measures aimed at preserving their health. Most members of VHT explained that even after introducing penalty fees for not complying with agreed action points, community members were not adhering to these action points. This signifies that although knowledge about health issues is important for mobilising communities to take care of their own health, such knowledge does not guarantee adherence to good health practices. It is therefore important that that behaviour change be promoted at individual and community level in order to enhance community participation in primary health care.

The study found out that people in Mukono Municipality did not see themselves as having much to do in primary health care delivery as they did not consider themselves as initiators or decision makers when it came to health matters in their communities. Participants in Focus Group Discussions were of the view that because the ordinary community members did not know how to read and write, all decision making and issues of planning should be done by the health facility. They said the community could not change or influence decisions which were made by the health facility.

However, when it came to the participation of community members in providing health services to people in the communities, the majority of discussants in the Focus Group Discussions said they were of the view that more community health workers needed to be trained because they were easily accessible than health facilities which were in most cases located very far away from the communities.

One of the discussants mentioned that *when she went to see a community health worker, she was given more attention than at the health facility. She said the community health worker was fast to attend to patients unlike at the health facility where patients waited for a very long time before being attended to. It was further mentioned by other participants that at the clinic, the nurse spent very little time with patients and did not ask or explain much to them. Some community members disclosed that they were more comfortable going to a community health worker than visiting a health facility. However, they complained that community health workers were rarely given drug kits hence could not do much to help patients in their communities.*

A female participant at a Focus Group Discussion in Nassuti held on 10<sup>th</sup> September, 2015 had this to say: *“In the past when CoU health centre mission was being run by the Church of Uganda, community health workers never ran short of drugs, we never used to go to the health facility frequently because community health workers were to attend to us. They could even visit sick people in their homes. Nowadays things have changed, even for headache you have to go to the clinic because the community health workers rarely have drugs, they do not even have transport to visit very sick people.”*

Some Village Health Committee (VHC) members also complained that although they were the representatives of their communities, they were less frequently invited for meetings and tend to know very little with regards to what is happening at the municipality health centers. They lamented that even though they were requested to make budgets for their communities, they were given figures or budgetary ceilings for all activities to be implemented at community level. These sometimes left out the most important things which the community wanted. In the same vein, the chairperson of Kauga Village Health Committee put it as follows during an interview held on 20th September, 2015:

*“The issue is the amount allocated to us is very little, our plans are shattered upon hearing the figure (on which) to plan from. For the 2014 activities we were told to budget*

*on about Ugx. 1,000, 000/=. Now what can you budget on this mount? We were all frustrated but we had to do the planning anyway so as not to sour the existing relationships which are there. We ended up planning for less important things.”*

Focus Group Discussion revealed that community members were more willing to go to a community health worker than going to the health facility. This was due to the fact that community health workers were more accessible and there were interpersonal relations which existed between community health workers and members of the community. Because they live together in the community, community health workers tend to know their clients very well. However, despite being regarded as important in the provisions of health services by community members, there were very few community health workers and they were constrained by limited training and shortages of drug kits. Furthermore, community health workers did not receive any support for their work, this acted as a disincentive to them.

The study found out that there were various issues which communities raised as obstacles to community participation in primary health care. At community level, members of the Village Health Committees (VHT) complained that they were no longer called very often for meetings at the Municipality Health Management as they used to. The excuse which had been given for this by the Mukono Municipality Health Management Team (MMHMT) was that they lacked resources to support such meetings. There were even complaints that community representatives were kept hungry at one of the meetings they went to attend. VHT also mentioned of being frustrated in their effort to participate in the budgeting process for community health activities because the indicative planning figures which they were given were too low. Besides the annual budgets allocated to community health activities being very low, VHT complained of erratic funding to community health activities by Mukono Municipality Health Management Team (MMHMT), this frustrated community effort in primary health care.

The finding is contrary to Omar, (2010), Participative decision making is important where a large number of stakeholders are involved from different walks of life, coming together to make a decision which may benefit everyone. In a participative decision-making process each team member of the community has an opportunity to share their perspectives, voice their ideas on how and what should be done to improve on the health service delivery on for example Child Health, Reproductive Health, Environmental Health and sanitation, Health Education and Promotion and Oral Health and Hygiene.

Most people in Mukono Municipality were ignorant of the structures put in place to foster community participation. They did not know how these structure operated as well as what the roles and responsibilities of community members where. Some households did not know that as community members, they had a role to play in health care delivery in their communities.

It was also learnt that some people lacked interest to participate at the community level in primary health care. Even when meetings were called, others did not see the need of participating because they did not see any immediate benefits in doing such. This was precipitated by the high level of ignorance which made it difficult for some community members to understand how certain issues were of direct benefit to them.

Members of the community could also not participate in in primary health care programmes like attending community meetings due personal commitments. Others were not available when meetings were called because they were too busy with personal things. High poverty levels also affected people participation in primary health care activities. At a household level, it was reported that some household could not afford the cost for labour and materials to build sanitary facilities. Individuals also found it difficult to raise money in order to make monetary contributions to health care projects in their areas.

Community members also complained of lack of adequate support to community health workers. It was learnt that community health workers were de motivated to participate in health care programs because they were rarely provided with kit to enable them provide services to people in their communities. Majority of community health workers had to cover big catchments and were not provided with any form of transport, this hampered their efforts in terms of reaching out to people in their communities. Community health workers did not also receive any form motivation of their work. This made it difficult for them to sustain their efforts of providing services to the communities. Furthermore, community health workers were not given extra training to enhance their skills. Some community members also complained of the distance they had to travel to attend meetings. They said even when meetings were called at the health center or health post, it was difficult for them to attend because the distance they had to cover to get to the meeting was too long. This was worsened by the fact that some people did not have transport. Lack of accountability and transparency also made it difficult for the community to participate in primary health care. Some community members could not make financial or material contribution towards health projects because they did not trust their leaders. Lack of transparency

and accountability had also created mistrust between the community and their leaders. When VHT asked for contributions from the community some people refused to contribute as they thought everything was funded by government.

The obstacles which community members face towards participating in primary health care delivery do not only frustrate community involvement but also excludes community members either individually or collectively from assuming greater responsibility for their health needs and problems. Community participation is cardinal for effective delivery of primary health care because the outcomes of community participation in the health sector include more health consciousness which pushes up the demand, more access to health care through community health workers and improvements of community level health infrastructure.

### **5.1.2 Information sharing and health service delivery in Mukono Municipality**

The results show that the Pearson correlation coefficient ( $r = .925^{**}$ ) and its significance level 0.000. This implied that information sharing influenced health service delivery. Therefore according to the results there is a positive significant relationship between information sharing and health service delivery. Table 4.8 results revealed that that 80% identified health facilities had outreach posts or centers in the communities where they went to share information about health services. The number of outreach posts or centers for these health facilities ranged between five (5) and twelve (12). During the outreach programmes, the major Information services shared were on; HIV/AIDS education, condom distribution, testing and counseling, Education and Communications. Growth monitoring and promotion activities were provided to children below 5 years. Immunisation services, antenatal care, family planning and safe motherhood services were also offered at outreach post or centers.

10% of the respondents identified health facilities were collaborating with schools by providing health services to children in schools. The services provided were physical inspection or screening of children for diseases, deworming, tetanus injections to pupils, provision of vitamin A and inspection of school premises to ensure a healthy learning environment. Most of the identified health facilities, 80% organised meeting in the villages to educate community members on health issues such as environmental health, sensitisation on HIV/AIDS prevention, treatment, care and support, malaria prevention, safe motherhood, family planning and PMTCT (Prevention of Mother to Child Transmission of HIV/AIDS).

25% identified health facilities organised events in the communities such as soccer tournaments, drama, traditional dances and popular theater. These events were aimed at mobilizing people who came to attend such activities to access health services. On the sides of these events, VCT and family planning services were provided. These health facilities also made use of local and national events being commemorated in their communities such as the Independence Day, World AIDS Day, local sports tournaments and traditional ceremonies to provide health services and health education at such gatherings. 15% identified health facilities conducted household visits to inspect sanitary facilities. 20% health facilities had trained malaria agents who were providing indoor residual spraying to households in their community. Sensitisation on hygiene and malaria were also done during household visits. The findings of this research are similar to those by Newman et al (2003) the study found that low use of public health centers was attributed to issues of accessibility, long waiting time, short or inflexible opening hours, shortages of staff and drugs, poor staff attitude and lack of confidentiality in socially stigmatized diseases.

Regular outreach activities by health facilities are important in promoting the health of the people in the communities. Through outreach services, health facilities are able to promote their services and educate people on health issues. This information sharing enables people to prevent and control diseases at an individual level. However, very few of the identified health facilities conducted outreach activities. Furthermore, even the few health facilities which conducted outreach activities were not able to do them on a regular basis. These health facilities were therefore not able to effectively prevent diseases at community level. The findings corresponds to the World Bank report (2009) in which it was found out that there were weaknesses in health education and promotion activities by primary health care facilities. Only 33% of people reported having received health education and outreach services. The study found out that less than 25% of health facilities were able to conduct regular information sharing on health education activities. This significantly contributed to the rise in preventable diseases within the community. The finding is contrary to The major causes of dissatisfaction with service provided by health facilities in Mukono Municipality were long period of waiting time, lack of personnel and shortages of drugs and supplies. Although other reasons like lack of respect or attention, quality of service provided and cleanliness of the surrounding were mentioned, they were not a big factor. Patient satisfaction with services provided at health facilities is very important as this can encourage or discourage them from using the health facilities. When households are dissatisfied

with services provided, they tend to under utilise health facilities. The findings of this study are agree with Afro barometer (2011). The study also revealed that although primary health care facilities existed in Mukono Municipality, they were inadequate as population growth had outstripped the capacity of available facilities to satisfy the demand for health service. The available health facilities were also poorly maintained and lacked basic amenities. The majority of health facilities provided most of the health services which are supposed to be provided at primary health care level although oral health and mental health services were not provided in all the health facilities. Very few health facilities provided youth friendly services as well as Antiretroviral Therapy (ART). There was also lack of integration in the provision of primary health services. Access to particular services was limited to specific days which were allocated by the health facilities due to limited information sharing. Household satisfaction with services provided by health facilities was low due to various problems such as long period of waiting time at the health facility, staff absenteeism and shortages of drugs; having identified primary health care facilities, the services provided and availability of services.

### **5.1.3 Consistent community feedback and health service delivery in Mukono municipality.**

Results in chapter four Table 4.13, indicated that feedback affected health service delivery in Mukono Municipality ( $r=.052$ ;  $p>0.73$ ,  $<0.05$ ). The study results therefore show that the feedback has a positive relationship on health service delivery though the relationship is not significant. Since the Pearson correlation coefficient 0.52 is significant at 0.000 being less than 0.05(alpha level), there is a strong positive relation between feedback lead and health service delivery in Mukono Municipality. The goal of feedback was to promote good health that is to enable individuals and communities live healthier lives. Primary health care ensures that the right provider is offering the right care at the right time and at the right place. Effective primary health care means individuals, communities and families actually participate actively in issues affecting their health. The finding is complimentary to the World Health Organization (2009) which explained the importance of access to primary health care as to improve the health of individuals.

According to the District Medical Office (2011) Mukono Municipality experiences a number of preventable and treatable diseases. There were a total of 353 deaths in 2010 and the ten major causes of death were pneumonia 16.7%, severe malnutrition 12.2%, diarrhea 10.2%, anemia 9.9%, cryptococcal meningitis 9.1%, cardiovascular disease 6.2%, TB 4.8, digestive system

4.0%, severe diarrhea 2.8%, pneumonia 2.5% and other diseases accounted for 21.6%, Mukono Municipality Health Strategic Plan (2011). Mukono Municipality has an HIV/AIDS prevalence of 17.6% compared to the national prevalence rate of 14.3%, only 33.5% of births in the district are delivered by a skilled provider compared to the national average of 46.5%. It is also estimated that 58% of women in the municipality did not get post natal checkup compared to the national average of 50.5% and the prevalence of diarrhea in children is 18.9% compared to the national average of 15.5%. Central Province is among the districts with the highest number of child and maternal mortality rate in the country.

Mukono Municipality also has a number of community health workers who provide services to people in their communities. Community Health Workers (CHWs) are just one of many terms used to describe an indigenous outreach health worker. They are also known as community health aides or advisors, lay health advisors, community health motivators, community health advocates and community health volunteers. In general, CHWs are local lay community members who interface directly with residents in the community to convey a variety of health messages that promote health and to improve access to and utilisation of health services. As frontline health care professional, CHWs have essentially three primary functions; (i) to serve as mediators between community members and health agencies (ii) to establish a social network, and (iii) to offer a range of services from emergency care to health protection and social support

The services included preventive services such education on HIV/AIDS prevention, male and female condom distribution, HIV/AIDS counseling and testing, HIV/AIDS awareness raising and Prevention of Mother to Child Transmission (PMTCT). There were variations in the provision of HIV/AIDS care and support services offered by health facilities, only 52% provided Home Based Care, 10% provided nutritional support to HIV/AIDS positive patient. Disease monitoring was only provided in 8% of the identified health facilities. All the identified health facilities provided nutritional sensitization as well as psychosocial counseling to HIV/AIDS positive patients. Antiretroviral Therapy (ART) for adults and children was only provided in 2 out of 20 health facilities. Prevention of Mother to Child Transmission (PMTCT) prophylaxis was provided in all the health facilities. Prophylaxis was provided to pregnant mothers at antenatal as well as to newly born babies to prevent transmission of the virus from the mother to the child but in all services feedback was as low as 15%.

These health facilities were not able to prevent the causes of diseases in communities thus making communities vulnerable to contracting preventable illnesses. Client feedback is an important component of two primary health care strategies: participation and evaluation. Workers need feedback from clients to ensure that their practice meets the criterion of providing affordable, accessible and appropriate services to enhance the health of their communities.

## **5.2 Summary of the major findings**

### **5.2.1 The influence of participative decision making on health service delivery in Mukono Municipality.**

There was a strong positive correlation between participative decision making and health service delivery (that is 0.883\*\* being significant at 0.000 less than 0.01(alpha level). There were variations in the types of community health workers and services provided. Most people did not understand how structures put in place to foster community participation in health care functioned. At the individual level, people were still not able to take care of their own health as there were negative attitudes towards community participation in primary health care. The study has also identified lack of motivation, distance, ignorance, poverty, lack of transparency and personnel commitments as obstacles to community participation in primary health care in Mukono Municipality. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asks patients about such things as communication with doctors, communication with nurses, responsiveness of hospital staff, and communication about medicines

### **5.2.2 The effect of information sharing on health service delivery in Mukono Municipality.**

There is a strong positive relation between information sharing on health service delivery at mukono municipality. The study established that physical, social, economic, cultural, quality of services provided and information barriers hamper access to health services by people in Mukono Municipality. Distance to the health facilities coupled with poor state of roads act as a disincentive in accessing health services. Hence lack of adequate information on the services hinders people from accessing health services. On the contrary, malaria prevention and control programme managed to reduce malaria cases from 95,000 in 2010 to 6,400 in 2015. Strategies which were used are early diagnosis, prompt treatment, promotion of mosquito nets, in - door

residual spraying, Information, Education and Communication (IEC) materials and community conversations. Furthermore, the study found out that by training community members in Direct Observation Treatment (DOTS) 15% of tuberculosis patients were being cared for by community members. The programme had promoted early detection and effective treatment of the diseases.

### **5.2.3 Consistent Community Feedback and Health Service Delivery**

The results using Pearson's correlation coefficient revealed that there is Relationship between participative decision making, information sharing *and* Consistent Community Feedback and health service delivery ( $r=.052$ ;  $p>0.73$ ,  $<0.05$ ). This is explained by the positive correlation coefficient between the three variables ( $r = 0.052$ ). Low levels of participative decision making, information sharing *and* Consistent Community Feedback make health service delivery difficult in Mukono municipality. Having effective Consistent Community Feedback strategies improved health service delivery. Staff at all levels should be engaged in obtaining feedback and the information gained should be disseminated throughout the agency in order to improve the quality and effectiveness of services. The challenge is now for service providers and users to adopt new, and support currently successful, ways of obtaining and using feedback so that service providers and users are engaged in working in partnership to ensure the needs of the community are best met.

## **5.3 Conclusions**

### **5.3.1 Participative decision making and health service delivery in Mukono Municipality.**

Pearson correlation coefficient 0.883 is significant at 0.000 being less than 0.01(alpha level), therefore, there is a strong positive relation between Participative decision making and health service delivery at Mukono municipality. Mutual collaboration and engagement is possible between health professionals and community members for the skilled delivery program. Community leaders, traditional and political leaders, volunteers, and TBAs have need to be all instrumental to the success of the health service programs. However, inadequate transportation, infrequent supply of drugs, attitude of nurses remains as challenges, hindering women accessing maternity services within Mukono Municipality communities. The study by Das Gupta and Rani (2003) was important to this research because it highlighted the interventions which are necessary for strengthening primary health care such as undertaking awareness raising activities to prevent ill health and involvement of communities, individuals and households in primary health care. This research benefitted from the literature because it sought to find out what

outreach activities were carried out by primary health care facilities in Mukono Municipality district. However, this literature did not tell us about the level of community participation in primary health care. It was important to find out if community members are able to prevent ill health at household level. There was also need to find out if the community was involved in planning, budgeting and implementation of primary health care activities. Furthermore, this research found out the knowledge, attitudes and perceptions of the community members towards participation in primary health care as well as the obstacles to community participation in primary health care.

The study has concluded that there is poor community participation in primary health care delivery in Mukono Municipality. As discussed in chapter four community participation in primary health care in Mukono Municipality is hindered by limited training of community health workers, lack of motivation, lack of interest, personal commitments, ignorance and inadequate support to community health workers.

In order for primary health care to be effective in rural areas, the community must be able to participate at both individual and community level in the provision of health care. Individuals should be involved in making decisions with regards to areas of intervention, utilization of resources by primary health care facilities and in deciding on what programs are to be implemented by the health facilities. The expected outcomes of community participation in the health sector include more health consciousness which pushes up the demand, more access to health care through community health workers and improvements of community level health infrastructure. The availability of community health workers in different areas of primary health care is essential for improving the health of people in the community as this brings health care closer to the people.

### **5.3.2 Information Sharing and Health service delivery in Mukono Municipality**

The study results showed that there is Relationship between Information Sharing and Health service delivery in Mukono Municipality ( $r=0.925$ ;  $p>0.035$ ,  $<0.05$ ). Information sharing was found out that strengthening primary health care was an effective means of reducing communicable and non communicable diseases like HIV/AIDS, tuberculosis and malaria. In combating HIV/AIDS, the strategies used were prevention, care and surveillance. For sexually transmitted diseases, information sharing through raising awareness and condom provision were part of the prevention programme which was used. Knowledge of HIV/AIDS grew and the

programme managed to reduce HIV/AIDS infections by 10% within a year although within mukono municipality areas, the prevalence rate remained high due to low level of knowledge about the diseases.

It has been established that physical, social, economic, cultural, quality of services provided and information barriers hamper access to health services by people in Mukono Municipality. Distance to the health facilities coupled with poor state of roads act as a disincentive in accessing health services. Although the government adopted a policy of free health care, there were still indirect costs to accessing health services which people incurred hence lack of income was still an obstacle to accessing health services. Hence lack of adequate information on the services hinders people from accessing health services.

### **5.3.3 Consistent community feedback and health service delivery in Mukono municipality.**

The study has concluded that although health facilities exist in Mukono Municipality, they are inadequate to meet the needs of people in the communities. Lack of access to information and Consistent community feedback in primary health care facilities acted as barriers to accessing health services. Access to clean water and sanitation in the Mukono municipality was low, many people use shallow wells and streams as a source of water. The number of people without sanitary facilities is also high. Mukono Municipality experiences a high prevalence of preventable and treatable diseases which lead to high mortality rates. The transport system in the district is bad mainly due to poor road infrastructure. The Mukono Municipality Health Management Team (MMHMT) which is a decentralized agency of the central government is responsible for managing health care delivery in the municipality.

The overall regression model in table 4.14 indicated that predictor variables of community participation (Participative Decision Making ( $P_{dm}$ ), Information Sharing ( $I_s$ ) & Feedback( $F$ ) explain 94% of variations in health service delivery. Results show a significant model ( $F=7.002$ ,  $sig = 0.003$ ) to explain a multi regression equation of health service delivery ( $y$ ) =  $1.172+0.326(P_{dm})+0.260(I_s)+0.458F$

#### 5.4 Recommendations

The study recommends that the following be done to improve community participation in primary health care in Mukono Municipality:

Train more community health workers; Scale up of behaviour change communication to enable people assume responsibilities for their health at individual, household and community level; provide adequate support to community health workers through regular provision of drug kits and empowering them with income generating activities. Community health workers should be trained, motivated and provided with necessary logistics for them to do their work. Community members should also be able to exercise healthy practices in their everyday lives. The ability of individuals to take care of their own health is essential for effective delivery of primary health care.

All healthcare providers need to understand how their staff perceive the risks of breaching information governance rules. They should use this information to make sure that staff understand the risks and consequences of poor information governance by tailoring the training for staff accordingly.

Collection and use of feedback are discouraged by inappropriate methods and timing, and clients' lack of awareness of, or confidence in, giving feedback about the services they receive. Verbal feedback, although preferred by many clients, is less likely to be recorded and used in service planning and evaluation. Client feedback is a valuable tool to reinforce the notion of partnership and power sharing between clients and health care workers.

The study recommends that availability of equipment in health facilities should be improved by: establishing and maintaining an equipment database system which will provide information on the status and adequacy of equipment in primary health care facilities; developing and implementing appropriate equipment development plans so as to ensure a planned and coordinated approach to equipment management, ensuring compliance with the established maintenance policy and guidelines at all levels and improving capacities for management and maintenance of equipment at all levels.

The study recommends that the number of health facilities should be increased in order to increase health service delivery capacity in Mukono Municipality. Expansion of existing health facilities should also be done to enable them cope with the increase in demand for health services due to population growth.

The study recommends that there should be integration in the provision of health services in health facilities so that people should be able to access all the services they need whenever they visit a health facility.

The study recommends that the distribution of drugs to health facilities should be strengthened to make it more effective by; ensuring adequate supply of drugs to health facilities by giving them more than the average quarterly allocation they get and; developing and implementing a contingency or emergency plan to sustain the supply of drugs in an event of stock outs.

## **5.5 Areas for further research**

The following areas are suggested for further research;

- To examine the effect of trained personals on the quality of health services
- To assess the factors influencing men's involvement in maternal and child health care services
- To investigate the Factors Contributing to Sexually Transmitted Infections Among Women of Reproductive Age
- To establish quality and quantity of information women need on risk factors that makes them susceptible to STIs
- To examine the Knowledge, Attitude And Practice Of Female Youth Towards Family Planning

## REFERENCES

Advancing the science of community-level interventions. *American Journal of Public Health*. 2011;101:1410-1419

Amin, M. E. (2005). *Social Science Research Conception. Methodology and Analysis*. Kampala, Makerere University printery.

Auma Jane-Frances, N. (2011). *The Ugandan Government's commitment to the Right to Health: A focus on Village Health Teams (VHT) and the rural poor*, The Hague, The Netherlands November, 2011

Bjorkman, M. and J. Svensson. (2009). "Power to the people". Evidence From a Randomized Field Experiment on Community Based monitoring in Uganda. *The quarterly journal of Economic* Volume 124:2, 735-769 (2009)

Broring, G. (2011). *Overcoming barriers: Migration, marginalization, and access to health services*. AMOC/Correlation Network for Social Inclusion and Health: Amsterdam, Netherlands.

Carlisle, S. (2010). Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland. *Critical Public Health*, 20(1), 117-127.

Chiu, L. F. (2008). Engaging communities in health intervention research/practice. *Critical Public Health*, 18(2), 151-159.

Cheema, Shabbir G. Dennis A. Rondinelli, eds. (1983) *Decentralization and Development: Policy Implementation in Developing Countries*. Beverly Hills: Sage

CORE Group. Save the children and US Agency for International Development (USAID) (2010). *Community case management essentials. Treating common childhood illnesses in the community: A guide for program managers*. Washington D.C. CORE Group, Save the children and USAID.

Cornwall, A. Lucas H, and Kath P, *IDS Bulletin* Vol. 31, No. 1, January 2000 pp. 1 13  
Accountability through Participation

Crigler, L. Hill K. (2009). *Rapid assessment of community health worker programs in USAID priority MCH Countries USAID Health care improvement project 2009*.

Dawson, S. (2001). *Community Involvement in Health Services in Rural Communities*. Christchurch: National Centre for Rural Health.

- De Luque, M. F. & Sommer, S. M. (2000). The impact of culture on feed-back-seeking behavior: An integrated model and propositions. *Academy of Management Review*, 25(4), 829–849.
- Donatelle, R. (2009). Promoting Healthy Behavior Change. *Health: The basics*. 8<sup>th</sup> edition. San Francisco, CA: Pearson Education, Inc.
- Dyer, S. (2004). Rationalizing public participation in the health service: the case of research ethics committees. *Health and Place*, 10(4), 339-348.
- Government of Uganda. Health Sector Strategic Plan 2014-2015
- Falleti , T. (2003). Governing Governors: Coalitions and Sequences of Decentralization in Argentina, Colombia and Mexico. Ph.D. Thesis, Political Science, Northwestern University: Evanston, IL.
- Fountain, J. Patel, K. & Buffin, J. (2007). Community engagement: the centre for ethnicity and health model. Migration, marginalization, and access to health services. AMOC/Correlation Network for Social Inclusion and Health: Amsterdam, Netherlands.
- Gelmon, S. & Holland, B. (1999). Final report of the Health Professions Schools in Service to the Nation Program. San Francisco: UCSF Center for the Health Professions
- Hamburg, M. (1998). Eliminating racial and ethnic disparities in health: Response to the Presidential Initiative on Race. *Public Health Reports*, 113,372-375.
- Health Records and Information Privacy Code of Practice 2005 (NSW)*
- Howie, E. Sy, S. Ford, L. & Vicente, K. J. (2000). Human-computer interface design can reduce misperceptions of feedback. *System Dynamics Review*, 16(3), 151–171.
- Jabbar, A. M. & Abelson, J. (2011). Development of a framework for effective community engagement in Ontario, Canada. *Health Policy*, 101(1), 56-69.
- Jacobs, Alex et al. (2010) Three approaches to monitoring feedback systems, particularly monitoring and Evaluation and logical frame work.
- Jones, D. (2010). Assessment of parenting. In: *The child's world: the comprehensive guide to assessing children in need*. London: Jessica Kingsley.
- Kaner, S. Lenny, L. Toldi, C. Fisk, S. & Berger, D. (1998). *Facilitator's Guide to Participatory Decision-Making* (2nd Ed.). San Francisco, DC: Jossey-Bass

Kaye DK, Kakaire O, Osinde MO.(2011). Maternal morbidity and near-miss mortality among women referred for emergency obstetric care in rural Uganda. *Int J Gynaecol Obstet.* 2011 Jul; 114(1):84-5. doi:10.1016/j.ijgo.2011.01.026. Epub 2011 May 13

Keystone Accountability. (2009) Feedback systems for social purpose organisations

King, A. (2001). *The Primary Health Care Strategy*. Wellington: Ministry of Health

Krejcie, R.V., & Morgan, D.W., (1970). Determining Sample Size for Research Activities. *Educational and Psychological Measurement*

Lane, P. & Tribe, R. (2010). Following NICE a practical guide for health professionals on community engagement with local black and minority ethnic (BME) community groups. *Diversity in Health and Care*, 7(2), 105-114.

Litchfield, M. (2002). *The Successful Design & Delivery of Rural Health Services, Phase Two: The Meaning of Success*. Christchurch: National Centre for Rural Health.

McNamara, B. (2006) provider-specific cards: a tool for health sector accountability in developing countries. *Health policy and planning* Vol 21, No. 2

Ministry of Health.MoH. (2005). *Health sector strategic plan II 2005/06-2009/2010*. Kampala: Ministry of Health.MoH.

Ministry of Health.MoH. (2009).*Human resources for health bi-annual report*. Kampala: Ministry of Health.MoH.

Ministry of Health.MoH. (2009). *Policy guidelines on infant and young child feeding*. Kampala: Ministry of Health.MoH.

Ministry of Health. *Health Sector Strategic Plan III 2010/2011-2014/15'*. Kampala: Uganda

Ministry of Health. 2011. *Annual Health Sector performance Report Financial year 2010/2011*: Kampala: Ministry of Health

Ministry Of Health (MoH) '*National Health Policy 2009/10-2013/14'*10 November 2011.

Ministry Of Health, (MoH) (2010). '*VHT Strategy and Operational Guidelines'*

Ministry of Health.MoH. (2008). *Access to and use of medicines by households in Uganda*. Kampala: Ministry of Health.MoH

- Ministry of Health 2013. Annual Health sector performance Report for Financial year 2013/2014
- Misra, V. 2007. Pilot study 1, Andra Pradesh, India: Improving Health Services through Community Score Cards. Learning notes, Social Accountability series. Washington D.C: The world bank
- Muyomba-Tamale, L., et.al, (2011). Local Government Councils' Performance and public Service Delivery in Uganda: Mukono District Council Score-Card Report 2009/10. ACODE Policy Research Series, No. 45, 2011. Kampala.
- Nachimias. D. and Nachumias. C. (1981). Research Methods in the social Sciences. 2<sup>nd</sup> edition. New York: St Martin's press.
- National development plan (NDP). 2014/2015
- Namara-Wamanga, S. et. at. (2013). Local Government Councils' Performance and Public Service Delivery in Uganda: Wakiso District Council Score-Card Report 2011/12. ACODE Public Service Delivery and Accountability Report Series No.3, 2013. Kampala.
- Nikniaz, A. Alizadeh M. (2007) Community participation in environmental health: Eastern Azerbaijan Healthy Villages project. Eastern Mediterranean Health Journal 13(1), 186-192.
- Neema, et al (2011). Community participation in essential national health research process: Uganda's Experience.
- Omar, M. (1999) Health Sector Decentralization in Developing Countries, Unique or Universal Leads: UK.
- Pender, N. Murdaugh, C. & Parsons, M. (2005). Health promotion in nursing practice (5th ed.). Upper Saddle River, NJ: Pearson Prentice-Hall.
- Probst, T.M. (2005). Countering the Negative Effects of Job Insecurity through Participative Decision-making: Lessons from the Demand–Control Model. *Journal of Occupational Health Psychology*,
- Popay, J. (2010). Chapter 10: Community empowerment and health improvement. In Morgan, A., Davies, M., & Ziglio, E. (Eds) *Health assets in a global context: theory methods action*. New York: Springer.
- Sebastian, J.G. Davis, R.R. & Chappell, H. (1998). Academia as partner in organizational change. *Nursing Administration Quarterly*, 23(1), 62-71.

Sekaran (2003). Research methods for business. A skill building approach. New York, John Willy and sons.

Sullivan, A. Sheffrin, S. (2003) Economics: Principles in Action, Pearson Prentice

Svensson, J. and Bjorkman. M. (2009). (forthcoming). "Efficiency and Demand for Health Services: Survey Evidence on Public and Private Providers of Primary Health Care in Uganda". Washington, DC: World Bank.

Shah, M. K. (2003). Using Community Scorecards for Improving Transparency and Accountability in the Delivery of Public Health Services: Experience from Local Initiatives for Health (LIFH) Project. Malawi:

The World Health Report (2008). Primary Health Care: Now more than ever. Geneva: World Health Organization.

The World Health Report (2006). Working together for health. Geneva: World Health Organization; 2006.

World Health Organization (WHO) (2008). World health statistics 2008. Geneva: WHO.

World Health Organisation, Alma-Ata (1978): Primary Health Care, Geneva: World Health Organisation.

Webler, T. & Tuler, S. (2002). Unlocking the puzzle of public participation. Bulletin of Science, Technology & Society, 22(3), 179-189.

Yin, R. K. (2003). Case study research: Design and Methods. Newbury Park: Sage. *Henry Sanoff (2006)*, Origins of Community Design, Progressive Planning Magazine

Uganda Bureau of Statistics and Macro International. (2007). "Uganda Demographic and Health Survey," 1995, 2000 and 2006. Calverton, MD: Uganda Bureau of Statistics and Macro International, Inc.

Uganda AIDS Commission. (2006). "Sector Based Assessment of AIDS Spending in Uganda." November. Kampala

United Nations Development Programme (UNDP). (2007). Measuring human development: A primer. New York: UNDP.

Uganda National Bureau of Standards. Annual Report (2014/2015): Kampala

Uganda Bureau of Statistics (UBOS) and Macro International Inc. (2007). Uganda Demographic and Health Survey (2006). Calverton, Maryland, USA: UBOS and Macro International Inc.

US Department of Health and Human Services, National Institutes of Health. (2005)  
[www.nci.nih.gov/theory](http://www.nci.nih.gov/theory)





**SECTION B: PARTICIPATIVE IN DECISION MAKING AND HEALTH SERVICE DELIVERY IN MUKONO MUNICIPALITY**

7. Indicate by ticking the extent to which you agree with the following statements. Using the Likert scale: strongly agree (1), agree (2), disagree (3), strongly disagree (4), not sure (5)

		1	2	3	4	5
1	Subordinates are given an opportunity to get provide information on their illnesses affecting their state of health					
2	Participatory health planning helps to pursue objectivity in health service delivery					
3	At Mukono Municipality, community ideas are valued in deciding health service delivery					
4	Ideas generated during the community health meetings set priority for the area					
5	I participate in health matters to guide Mukono Municipality make correct health decisions					
6	Community participation allows Coordination of health services at the municipality					
7	Community participation enhances Negotiation for priorities					
8	Community participation enhances Planning for specific areas of responsibility					
9	Community participation improves Representation of the interests of my business					
10	Participation enhances quality of services make staff accountable for results					
11	I participate in decision making to influence the goals of health centers					
12	I participate in planning to exchange information for Mukono Municipality decision making					
13	With community participation budgeting, quality and efficiency of health services is realized					
14	Community Participation improves management of programmes and ensures optimum use of funds as well as quality of health service delivered					
15	Encourages Health education and promotion					

**SECTION C: INFORMATION SHARING AND HEALTH SERVICE DELIVERY IN MUKONO MUNICIPALITY**

8. Indicate by ticking the extent to which you agree with the following statements. Using the Likert scale: strongly agree (1), agree (2), disagree (3), strongly disagree (4), not sure (5)

		1	2	3	4	5
1	Improves health awareness and prevention of sexually transmitted infections					
2	Aids decision as to whether to use condoms, Abstinence, remain faithful to a partner, have Regular STI tests for quality of health services					
3	Reduces self-medication dangers					
4	Improves community mobilization about killer diseases					
5	Reduces malnutrition among children					
6	Increase cordial relationship among health workers and patients					
7	Improves coordination among health workers and the community					
8	Allows Prevention of Mother To Child Transmission					
9	Both husband and wife being involved with the wife in family planning					
10	Controls Social stigma & fatigue					
11	Permits health workers and mothers to share Antenatal care or postnatal care information					
12	Allows sexual discussions					
13	Information sharing allows learning family responsibility					
14	Allows decisions in using contraceptives					
15	Positive attitude of health workers towards Supportive services					

**SECTION D: FEEDBACK LEAD AND HEALTH SERVICE DELIVERY IN MUKONO**

**MUNICIPALITY**

2. Indicate by ticking the extent to which you agree with the following statements. Using the Likert scale: strongly agree (1), agree (2), disagree (3), strongly disagree (4), not sure (5)

		1	2	3	4	5
1	Increases the number of times a pregnant woman attends ANC					
2	Aids to review the quality of information, enable programmed child spacing					
3	Social contact and interpersonal support influence Individual/couple decisions on health matters (e.g. when to have children, number of children)					
4	Positive feedback enhance attitude & knowledge towards positive health living					
5	feedback improves maternal and child health care services					
6	Feedback on delivery and postnatal care and baby enhance health living					
7	Feedback allows Treatment of ailments and review of treatment					
8	Feedback about family planning methods reduces cancer					
9	Feedback makes Mukono community knowledgeable about sexual matters					
10	Feedback enhances willing to undertake preventive measures against STIs					
11	Care provided to a pregnant mother at delivery can be reviewed by during pregnancy and after delivery					
12	Feedback allows being free with the health workers at the ANC clinic					
13	Feedback on health workers welcoming , Rudeness & Disrespect enhances better health services					
14	Feedback promotes positive feeling towards discussing family planning					
15	Abnormal fetus development, Complicated delivery, Loss of pregnancy or death					

**Section E: Service Delivery**

How are the following service delivery indicators observed among the health workers of Mukono Municipality. Please indicate the extent to which you; strongly disagree (1), Disagree (2), Not sure (3), Agree (4), Strongly agree (5)

	<b>Service delivery</b>	5	4	3	2	1
1	Health Workers are able to produce out puts in the right quantity because of community participation extended to them by Mukono Municipality.					
2	I am able to deliver quality services at Mukono Municipality. because of the attractive community feedback offered to me					
3	Our clients are satisfied with the delivered public goods and services because of information sharing at health centers					
4	The work we deliver as a team is rated excellent by the community we serve because of its quality					
5	All staffs at health centers in Mukono Municipality are committed to deliver because of the community involvement in health matters					
6	Health officers are able to deliver innovative ideas because of the community decision making in Mukono Municipality.					

**“Thanks for your Cooperation”**

## APPENDIX II: INTERVIEW GUIDE FOR THE COMMUNITY MEMBERS

Dear Respondent,

I am, a final year student of Kyambogo University pursuing a Master's Degree in Organization and Public Policy Management of Kyambogo University. I am conducting a study on: *“Community Participation and Health Service Delivery at Mukono Municipality Health Centres”*. I am required to submit a research report as part of the partial requirements for the award of Master's in Organizational Planning and Public Policy Management. The purpose of this interview guide is to gather information to enrich the study findings. The study shall be entirely academic and thus any information provided will be treated with utmost confidentiality.

1. How do you understand health as a basic human right
2. What health challenges does your community face?
3. What health services make clients happy within Mukono Municipal council?
4. What makes the clients to value or perceive the health services provided to them?
5. How does community participation influence the delivery of health services at health centers in Mukono municipality?
6. How is community Participation encouraged at Mukono Municipality Health Centres?
7. What are the forms of community participation at Mukono Municipality Health Centres?
8. What are the roles of community Participation in decision making at Mukono Municipality Health Centres?
9. What challenges affect health service delivery at Mukono Municipality Health Centres?
10. How does management at health centers overcome community involvement challenges?
11. What is the relationship between community Participation in decision making and service delivery at Mukono Municipality Health Centres?
12. What are the factors that affect health service delivery in Mukono Health Centres?
13. To what extent does health service delivery contributes to client Satisfaction?
14. What do you think needs to be done to improve the effectiveness of health service s in Mukono municipality?
15. What measures can be adopted to improve health service delivery?

*“Thanks for your cooperation”*

#### APPENDIX IV: SAMPLE SIZE DETERMINATION USING KREJCIE AND MORGAN

The ever increasing need for a representative statistical sample in empirical research has created the demand for an effective method of determining sample size. To address the existing gap, Krejcie & Morgan (1970) came up with a table for determining sample size for a given population for easy reference.

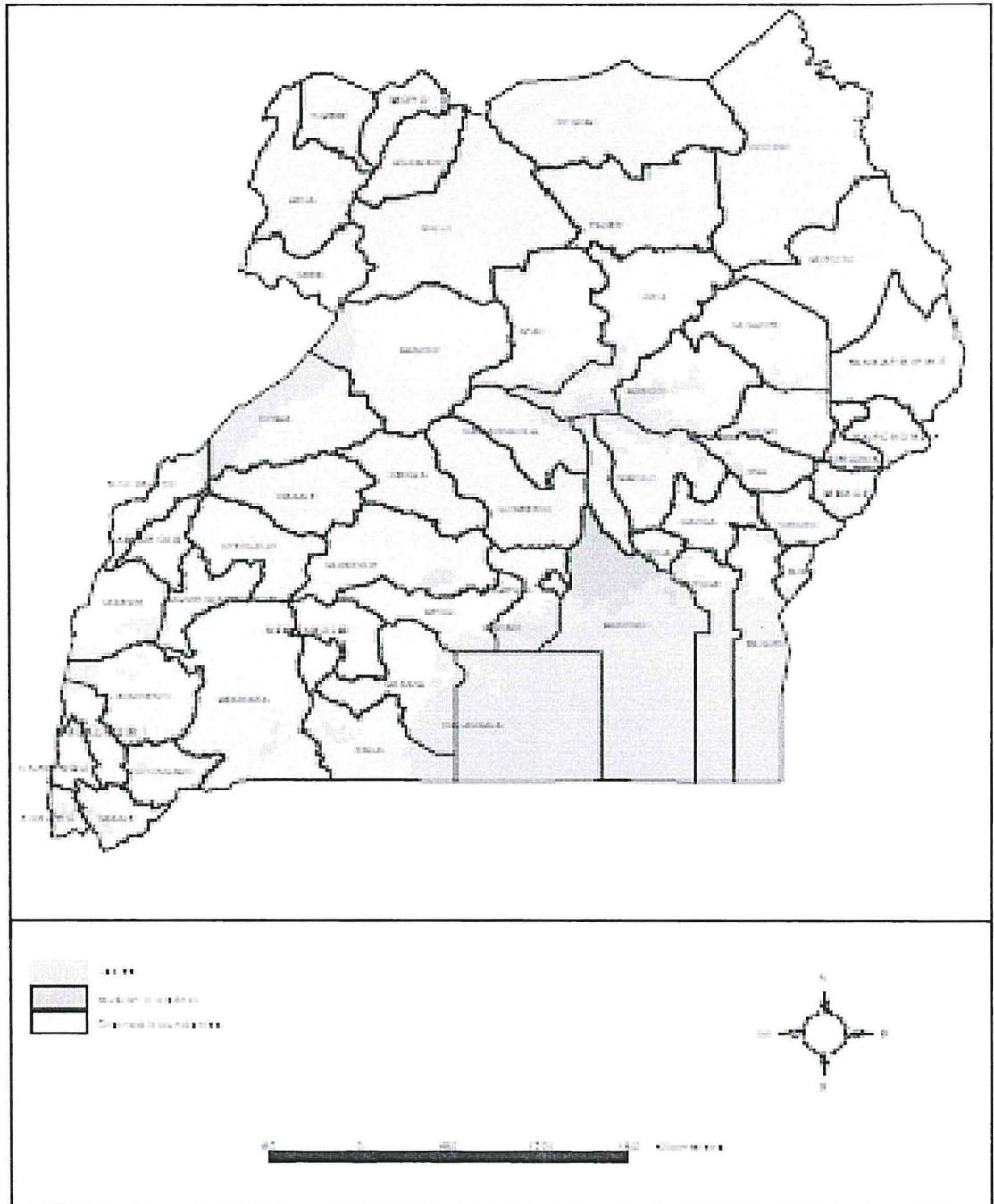
Table 1: Table for Determining Sample Size for a Finite Population

<i>N</i>	<i>S</i>	<i>N</i>	<i>S</i>	<i>N</i>	<i>S</i>
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3300	346
85	70	440	205	4000	351
90	73	460	210	4300	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367
130	97	650	242	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379
180	123	900	269	40000	380
190	127	950	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	100000	384

Note.—*N* is population size. *S* is sample size.

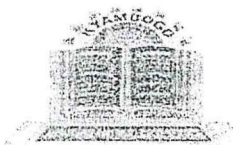
Source: Krejcie & Morgan, 1970

APPENDIX V: A MAP OF UGANDA SHOWING MUKONO DISTRICT





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*Office of the dean, Graduate School*

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28<sup>th</sup> August 2015

*To Whom It May Concern*

RE: LETTER OF INTRODUCTION

Dear Sir/Madam,

This is to introduce **Ms. Marachto Shirley Registration number 13/U/2037/GMOP/PE** who is a student of Kyambogo University pursuing a Masters Degree.

She intends to carry out research on **“Community Participation and Health Service Delivery:” A case study of Mukono Municipality**” as Partial fulfillment of the requirement of the award of Master of Science in organization and Public Policy Management.

We therefore kindly request you to grant her a permission to carry out this study in your organization.

Any assistance accorded to her will be highly appreciated.

Yours sincerely,

Dr. M. A. Byaruhanga Kadooda

BK/ nmb

