PARTICIPATORY PLANNING AND DELIVERY OF HEALTH CARE SERVICES IN PUBLIC HOSPITALS IN UGANDA:

A CASE OF MULAGO HOSPITAL

BY

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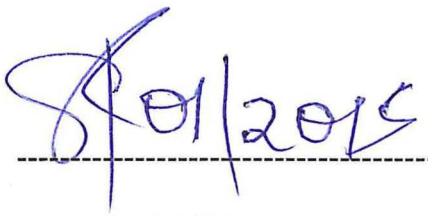
A RESEARCH REPORT SUBMITTED TO KYAMBOGO UNIVERSITY IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN ORGANIZATIONAL POLICY AND PUBLIC MANAGEMENT OF KYAMBOGO UNIVERSITY

JANUARY, 2015

DECLARATION

I, **Kagenda Javan,** declare that this research report is my original work that has never been submitted to any institution for any award.

KAGENDA JAVAN



DATE

APPROVAL

This research report titled "Participatory Planning and Delivery of Health Care Services in Public Hospitals in Uganda a case of Mulago Hospital, Kampala" has been submitted with my approval as a University supervisor.

Dr. Hilary Mukwenda Tusiime

Signature.....

Date 09-01-2015

Ms. Elaine Gombe

Signature.....

Date 09-01-2015

DEDICATION

This work is dedicated to my parents, my treasured wife Clare and children, brothers and sisters who were patient throughout my course.

ACKNOWLEDGEMENT

The writing of this dissertation has been one of the most significant academic challenges I have ever had to face. Without the support, patience and guidance of the following people, this study would not have been completed. It is to them that I owe my deepest gratitude. I am greatly indebted to Dr. Hilary Mukwenda Tusiime, my Principal Supervisor, who inspired me with his wisdom, knowledge and commitment that led to completion of this work. I am also indebted to Ms Elaine Gombe, my second supervisor and Dr. Jacob Oyugi Lalango Dean, Management School (2012) for technical guidance during my research. I appreciate your patience and commitment which was an encouragement. I also commend the staff of Mulago Hospital who diligently assisted me with information I requested for which was an asset regarding my research. I as well acknowledge all the support from Development Initiatives International (DII), the organization I work with which has tremendously contributed to my success. The teamwork exhibited with fellow course mates of the Master of Science Organizational Policy and Public Management. Words alone may not express my appreciation however, may God reward you generously.

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ABSTRACT

The study sought to investigate the relationship between participatory planning and service delivery in public hospitals in Uganda a case of Mulago. The study specifically examined the relationship between participatory planning and the scope (coverage) of services delivered to clients at Mulago Hospital; and assessed the relationship between participatory planning and timely accessibility of services; as well as established the relationship between participatory planning and quality of service delivered.

The study adopted a descriptive and case study design to allow for in-depth data collection and analysis, contextual understanding and description of the research problem. Correlation techniques were also used to measure the relationship between participatory planning and service delivery management in Mulago Hospital. Data was collected using interviews and questionnaires to randomly selected Mulago Hospital staff. Collected data were analyzed using both qualitative and quantitative techniques of analysis. Results revealed a positive and significant relationship between participatory planning and service delivery in Mulago Hospital.

Findings of the study revealed a significant relationship between participatory planning and health service delivery in general at Mulago Hospital. Management there fore needs to appreciate joint planning involving key stakeholders, sufficient communication systems and inculcation of the spirit of team work across the entire hospital for improved service delivery.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

World over, health is recognized as one of the fundamental rights to be enjoyed by every human being without distinction of race, religion, political belief, social and economic condition. Over the recent past more advances in health, science, and technology have been made in the last 50 years than in the 500 years before the 20th Century (World Health Organization, 2002). For instance, Health infrastructure has been expanded and education, incomes, and opportunities have improved. There are vast amounts of resources being funneled into global health work, such as vaccines, primary health care, drug therapies, maternal and child health care, and basic surgery.

Despite vast amounts of money, tools and interventions, the successful delivery and implementation of these resources remain elusive. Public health interventions and socioeconomic development have reduced mortality and raised life expectancy. Unfortunately, these gains have by no means been universal (Schirnding, 2002). Healthcare systems and governments worldwide are trying to curb rising costs while improving patient care outcomes. Governments all over the world are now showing growing interest in analyzing their own planning and service delivery processes from the perspective of particular groups of population.

However, Africa lags behind all continents of the world. Whereas Africa has 20% of the world's sick people, it has only 4% of its healthcare workers – many of them vulnerable to the high mortality rate associated with malaria and notably the AIDS epidemic. The state of investment in

healthcare infrastructure is also grossly inadequate as is the efficiency of healthcare delivery (World Health Development Report, 2004).

Yet, an appropriate, robust, and sustainable model for improvement in health system performance is essential in order to reverse the declining trends in health and development status and break the vicious cycle of poverty and ill-health in Africa (Kaseje, 2006). In Uganda, the provision of health services is funded by the Government of Uganda and Development Partners *(Ministry of Health Value for Money Audit Report, 2006).* A big proportion of the population in Uganda lives below the poverty line with 31.1% of the population living in absolute poverty *(Ministry of Health Value for Money Audit Report, 2006)*. This means that many people cannot afford private medical services and therefore require free medical services provided by Government. Historically, Uganda, like many newly independent countries in Africa, had a functioning healthcare system in the early 1960s, but saw a collapse of government services as the country underwent political upheaval. The government has been implementing major infrastructure rehabilitation programs in the public health sector, but improved outcomes have remained elusive. Rural dispensaries, which are the lowest tier of the Ugandan health system, provide preventive outpatient care, maternity, and laboratory services. In order to make health services accessible to the population, Government of Uganda decentralized health service delivery to districts and lower to health sub districts by reallocating resources to lower Health Centers.

Mulago hospital a national referral hospital has a 1:40 doctor to patient ratio (Youssouf, 2009). The situation is not far better when it comes to nurses. Most of the facilities at the hospital are in pathetic situation. The resultant effect of the situation is revealed by critical shortage of devices as well as chemicals which are essential for effective and efficient operation of the hospital.

Consequently Mulago hospital are overwhelmed by the over increasing demands of patients for hospital services. There has been increasing public outcry about the quality of services offered at Mulago hospital. One wonders whether participatory planning can help to alleviate the service delivery challenges being experienced at Mulago hospital.

Participatory planning is regarded as an act of taking part and sharing in something where we need to reflect needs of local people in accessing healthcare and treatment. The best way to find what people need and what they see as possible solutions to their problems is to ask them directly. Local officials, mass organizations and individuals, especially the poor must be involved in consultations and discussions. The researcher therefore sets out to explore why participatory planning is vital in healthcare service delivery in Mulago hospital.

1.2 Statement of the Problem

Despite Government's efforts to improve quality of health service delivery in Uganda by allocating more funds, little success has been met. Mulago hospital has capacity to admit 1500 patients, but admits 2500 (Youssouf, 2009). With patient-attendants, the number of people in each ward is almost always thrice that the space is designed for impacting on the quality of health services at Mulago national referral hospital. The poor and disadvantaged suffer in relation to delivery of healthcare services. First, they lack access to those services due to physical, financial, informational, political and other barriers. Second, they lack effective mechanisms for feeding back their complaints, views and requests in relation to those services due to limited participatory planning (Youssouf, 2009). This makes it difficult for Mulago hospital to deliver quality health services to its clientele on a daily basis. If the situation is not

handled urgently, health service delivery will drop further leading to many patients losing their lives and more people contracting deadly infections at the national referral hospital.

1.3 Purpose of the Study

To examine the relationship between participatory planning and delivery of health care services in Mulago Hospital in Uganda.

1.4 Objectives

The objectives of the study were:

1. To examine the relationship between participatory planning and the scope (coverage) of health care services delivered to clients of Mulago Hospital in Uganda.
2. To assess the relationship between participatory planning and timely accessibility to health care services offered at Mulago Hospital in Uganda.
3. To establish the relationship between participatory planning and quality of health care service delivered to clients of Mulago hospital in Uganda.

1.5 Research Questions:

Research Questions that guided this study were:

1. To what extent does participatory planning relate to scope (coverage) of health care services delivered to clients of Mulago Hospital?
2. What is the relationship between participatory planning and timely accessibility to health services offered at Mulago Hospital?
3. Does participatory planning influence quality of service delivery in Mulago Hospital?

1.6 Significance of the Study

Findings of the study revealed, there is a significant relationship between participatory planning and the scope / coverage, of service delivery in Mulago Hospital; there is a significant relationship between participatory planning and timely accessibility of health services and that there is a significant relationship between participatory planning and the quality of services delivered by Mulago Hospital.

Findings of the study may be used by stakeholders to better understand the influence of participatory planning to empower communities (including women, the elderly, children and other disadvantaged groups) to take appropriate actions for the promotion of their own health as true partners in healthcare services. Staff members at lower levels need to be involved in the planning, organization, management and implementation and monitoring of healthcare service delivery in order to advocate for better services including health information, skills, financial and other resources to ease their participation. Other researchers may use the findings on participatory planning, which may be used to carry out more research.

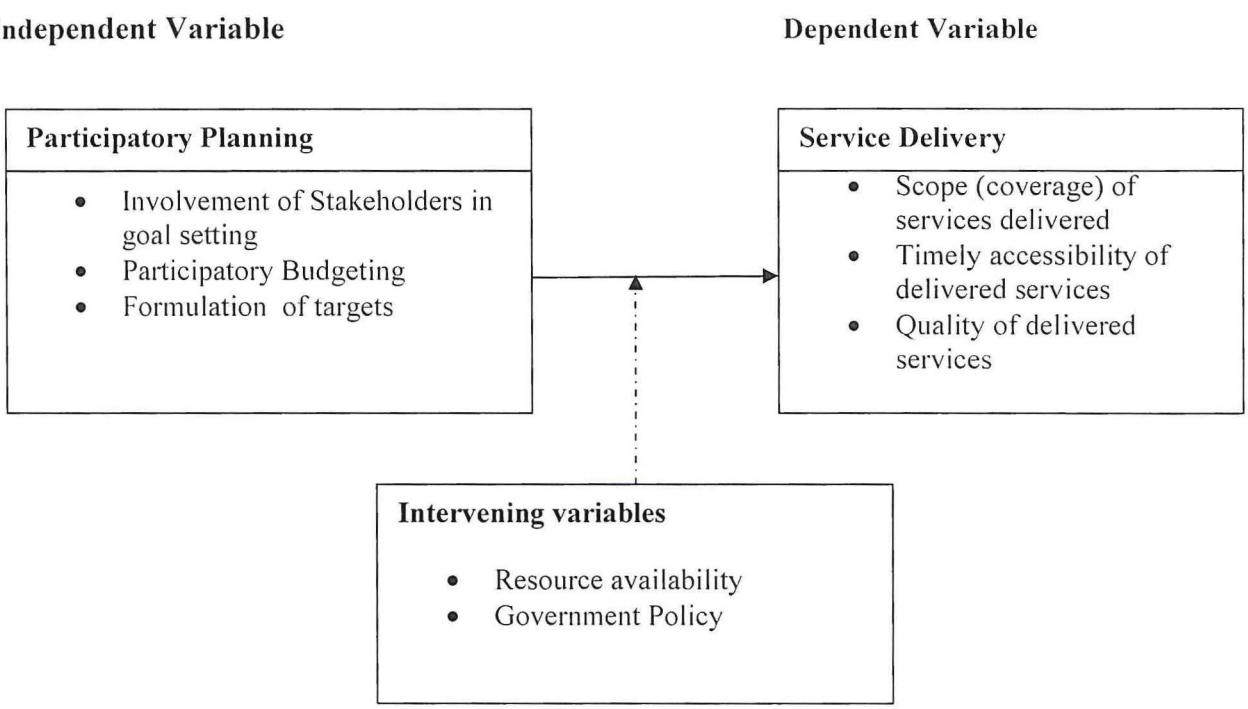
The study in a broad sense may also help hospital management and health personnel appreciate value for money in order to strengthen procurement, supply and distribution processes and minimize commodity wastage to justify more resource allocation for Mulago National referral hospital. The recommendations given may help management in public hospitals to institutionalize regular inventories and improve supply management procedures to ensure regular availability of essential medical products and rational use of essential medicines, commodities, equipment and to invest in infrastructure development and maintenance.

1.7 Scope of the Study

The study was carried out on participatory planning and service delivery at Mulago Hospital in Uganda. Mulago is a national referral hospital situated in Kawempe Division South of Kampala city in Uganda. The study specifically focused on the influence of participatory planning on quality scope (coverage) and accessibility to health services in Mulago Hospital. The temporal scope covered the period 2008 – 2012 because is a period when government of Uganda allocated more funds to the health sector to address health as a key priority. Mulago was chosen because of its national referral status (Ministry of Health, 2009).

1.8 Conceptual Framework showing the Relationship between Participatory Planning and Service Delivery.

Fig.1 Conceptual framework



Source: UNDP (1997), Spoelstra and Pienaar (1996), and Sebenius (Oct. 2006)

Figure 1, demonstrates how the study is conceptualized. The figure designates that health care service delivery depends on participatory planning. Therefore participatory planning entailing involvement of stakeholders in goal setting, participatory budgeting and formulation of targets are the independent variables while service delivery involving coverage, timeliness and quality of health care services delivered. The process of participatory planning is inevitable since communities have many interests amidst limited resources and social, cultural and political background.

The conceptual framework indicates that there are other factors which affect the delivery of health care services. These factors are shown by a dotted stripe since they are outside the scope of study. It also illustrates that there is a relationship between resource availability, management style and government policy despite being outside the scope of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents and reviews the relevant literature that has been documented by various scholars and authors in the area of study. The reviews are done in accordance with the major themes of the study as identified in the specific objectives. The reviewed literature helped to find out how much the research subject has been studied about and also identify gaps on which to develop research problem.

2.2 Theoretical Review

The Public Value Theory of Moore (1995) was used to underpin the study. Moore (1995) formulated the Public Value framework to imbue public sector managers with a greater understanding of the constraints and opportunities within which they work, and the challenge to create publically valuable outcomes. His central proposition was that public resources should be used to increase value not only in an economic sense but also more broadly in terms of what is valued by citizens and communities. Moore developed a 'strategic framework' in an attempt to capture the aims and constraints of public sector management and to help align goals, authorization and operational capability.

In the light of the Public Value theory, participatory planning is reflected in terms of citizens and communities broadly getting involved in the planning process. This is because when stakeholders (citizens and communities) are involved in the planning process, they become part

and parcel hence owning the process. This increases value in the eyes of citizens/beneficiaries of the services offered. Moore further observes that when stakeholders are involved in the planning process a greater understanding of constraints and opportunities is realized, which in turn enhances the use of public resources thereby increasing the economic value of resources, thus effective service delivery management in terms of quality and time management.

2.3 The Concept of Participatory Planning

According to Kleven, (1998:9) Planning is an attempt to reduce uncertainty about what the future may bring, by applying knowledge and expert insights in the task of achieving the objectives that the organization has chosen Planning as a goal oriented, rational problem solving method. Planning is necessary in order to ensure good decisions as a means of preparing action."

Participatory planning and development has been a growing trend over, roughly, the last 80 years (perhaps a longer period than would often be recognized, stemming as it did in colonial efforts to promote "community development" through forced "participation" by citizens. Participatory development thus started as a counterpoint to mainstream top-down planning and implementation enforced by national and international development agencies (Taylor and Fransman, 2004).

Shmueli, Kaufman and Ozama (2005) argued that planning in the local domain entails responding to and shaping anticipated social and research needs in the uncertain future. Planning is therefore joint decision making, which is in turn inherently transactional. This was supported by Ssewankambo (2008), Spoelstra et al (1996) and sustained by Kuye (2007, 1) who argued

that, it is through participation that conflicts in society caused by clashing interests, personalities and misunderstandings amidst limited resources can be resolved and services delivered according to agreed priorities and needs.

Tandon, 2005, observes that, the idea of participation first evolved in the mid-1970s. The trajectory of participatory methodologies, though gaining ascendancy in the past decade, has its roots in the cultural practices of community collectives in many societies. Its humanitarian visions derive their inspiration from the histories of struggles and conflicts for the promotion of a more just and humane social order across the globe. Participation has been defined by Bhatnagar and Aubrey (1992:6) in the following way: "Participation is a function of information through which people can come to share a development vision, make choices, and manage activities.

Around the world governance actors, analysts and activists are grappling with this issue, and exploring how best to engage citizens in government decision making, especially its policy-making processes. The reality is, however, that currently citizen participation in policy making is primarily reduced to participation by the elite, organized civil society in the form of predominantly non-governmental organizations (NGOs), business and other interest groups with access to resources. Crenson and Ginsberg (2002) refer to this monopoly of participatory processes by elite forces as 'downsized' democracy. Participation mechanisms that are established to channel citizen input are not accessible to the majority population in societies characterized by inequality, particularly marginalized communities and sectors, and typically do not 'automatically benefit poor people and groups that have long faced social exclusion' (Manor 2004: 5).

Citizen participation in governance is portrayed as having the potential to 'reduce poverty and social injustice by strengthening citizen rights and voice, influencing policy-making, enhancing local governance, and improving the accountability and responsiveness of institutions' (Taylor and Fransman 2004: 1). It has largely been assumed that as governments develop expertise in facilitating greater levels of participation, services tend to improve and things get better for those in situations of poverty. More and more, participation is seen as critical to the goals of poverty reduction and social justice but from varying perspectives. Where there is no genuine empowerment of citizens, the participation process simply becomes an 'instrument for managed intervention' (Cornwall 2002: 3). Discussing the consequences of superficial or cosmetic processes, Manor notes that 'If ordinary people find that what at first appears to be an opportunity for greater influence turns out, in practice, to be a cosmetic exercise if they gain little or no new leverage – then they will feel conned and betrayed' (2004: 9).

Relating to the policy-making process in Brazil, Shankland (2005:2) used a term which I believe could equally be applied to Uganda, namely, 'representation dressed up as participation', a flawed notion of political representation of citizens' interests through civil society organizations, which 'ignores the fact that debates in "new democratic spaces" occur in the absence of some (indeed most) citizens and with the presence of others who may be speaking in their name'..

In participatory planning, Fisher, Ury & Patton (1991) noted a contradiction between positions and interests of stakeholders. Positions are the demands that parties make or their preferred action to address a particular problem, while interests are concerns that motivate proponents to advocate specific solutions, the why behind positions. This was in agreement with assertions of

Shmueli, Kaufman & Ozama, (2004) that a focus on positions rather than interests may fail altogether to address stakeholders' primary interests during planning.

Experiences and reflections from civil society stakeholders suggest to us that although there is legislative provision for participatory mechanisms, and many such provisions are in place, this is not enabling civil society to participate meaningfully. The existing e mechanisms are inadequate, inaccessible and disempowering, and that new approaches to participatory policy making are required. The progressive end of this spectrum reflects a rights-based approach, recognizing participation as a right in itself, and an entry point to realizing all other rights Eyben (2003). As Cornwall (2002:16) notes, this 'recasts' citizens as 'neither passive beneficiaries nor consumers empowered to make choices, but as agents: the "makers and shapers" of their own development'. Eybeen and Ladbury (1997:195) in the World Bank's Learning Group on Participation stress the importance of: "employment which entails sharing power and raising level of political awareness and strength for disadvantaged people".

Craig and Mayo (1995) emphasize in the Human Development Report, (UNDP) that participation is "any form of access to decision-making and power', as well as in terms of economic participation". The term participation in this work is considered from the assumption that the development of the participatory approach to management begins with the belief that sustainable development ultimately depends on enhancing the people's capacities as individuals and groups to improve their own lives and take greater control over their own destinies. It is on the strength of this belief that the participatory approach identified in this book is considered to represent a considerable change, first in the process of governance, secondly, the social and

political relationships, and thirdly who participated in control and is empowered by the participatory process.

Slocum (2003) establishes that, a participatory approach actively involves the public in decision-making processes, whereby the relevant public depends upon the topic being addressed. The public can be average citizens, the stakeholders of a particular project or policy, experts and even members of government and private industry.

A series of specific challenges to community engagement, including stigma, language and cultural differences are identified including barriers regarding engagement of consumers and communities in health system planning, provision, reform and research. Time factors and geographic distance, consumer literacy further complicates the process adding to the difficulties in engaging consumers. Further, physical and psychological exhaustion of involvement is another barrier to the engagement of some people with disabilities.

2.4 The concept of Healthcare Service Delivery

WHO (2008) gives an overall working definition of integrated health service delivery as "The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system."

Health systems can, in the way they function strengthen the capabilities of individuals and social groups, for example, by including opportunities for people to participate in planning services, from individual care plans to community health interventions. They can generate preferential gains for society – disadvantaged groups, either by impacting on the structural factors that

disadvantage them by strengthening their ability to claim health resources or implement health actions through planning and budgeting (Loewenson and Gilson, 2011)

World Development Report (1999) developed a practical argument regarding implementation on quality and capacity of service delivery in the healthcare. Basing on the belief that quality of healthcare services are reflected in the capacity of the health departments or organizations to deliver, the commission argued that if a department met all expenditures on purchasing the proposed tones of drugs, medicines and sundries; If well stocked all the planned medical facilities; installed all the needed medical equipment; bought all the needed ambulances; spent on medical research and training as proposed; met the planned medical personnel salary and wage bill; and if it established the planned physical buildings, there would-be no doubt that the department's programme implementation would produce the desired level of service delivery, provided other factors are held constant.

In a service industry, like healthcare, experience of the patient plays a crucial role in rating and assessment of quality of services. The health sector comprises the public system with major players including the Ministry of Health and parastatal organizations, and the private sector, which includes private for-profit, Non Governmental Organizations, and Faith Based Organizations facilities. Health care service delivery looks at quality in healthcare as newer technology, newer and effective medication, and higher staff to patient ratios, affordability, efficiency and effectiveness of service delivery (Truong, 2004).

Ennis and Harrington (2001) assert that, in healthcare industry service quality has become imperative in providing patient satisfaction because delivering quality service directly affects the customer satisfaction, loyalty and financial profitability of service businesses. In healthcare,

service quality can be broken down into two quality dimensions: technical quality and functional quality. While technical quality in the health care sector is defined primarily on the basis of the technical accuracy of the medical diagnoses and procedures or the conformance to professional specifications, functional quality refers to the manner in which the health care service is delivered to the patients.

Zimmerman and Rappaport in Stein (1997) noted that as long as people are not empowered they cannot participate in decision making and influencing affairs that affect their lives. The implication is that: unless Local governments take the initiatives of empowering communities first, their participation in planning will remain minimal hence affecting service delivery. This is because participatory planning leads to learned hopefulness which means empowerment, and vice versa. In Local Governments, there is no guarantee that the community depends on skilled negotiators who can ably guide them in negotiating for services they need which is a pre-requisite for effective service delivery.

Prior to the 1990s, Uganda had a highly centralized healthcare system with considerable differences in health services standards between urban and rural areas (Jeppsson and Okuonzi 2000). After decentralization, the central government, through the Ministry of Health (MOH), is responsible for resource allocation and hospitals. However, it has devolved much of the responsibility of operating the lower health units, such as health centers and dispensaries, to lower levels of local government under the Ministry of Local Government. Health facilities run by faith-based organizations, which constitute 40 percent of the country's healthcare facilities, offer better services than non-faith-based facilities (Jeppsson & Okuonzi, 2000).

2.4.1 Participatory Planning and Scope/Coverage of Service Delivery

To Rahman and Kabir (2004), Participatory planning is said to be the first step of participatory budgeting exercise which aims at coverage of scope. The participatory planning process is based on the activities (scope coverage) intended to establish rapport building with the communities which further are strengthened by participatory rapid appraisal (PRA) exercises undertaken at lower local levels. Further, for purposes of scope coverage, (Rahman and Kabir 2004), highlight four steps of participatory planning and these are: infrastructure mapping, problem identification and prioritization, scheme identification and prioritization and finally short listing. Short listing defines the scope to be accomplished. Studies have revealed positive strong correlation between participatory planning and effective scope coverage.

Various scholars have tried to establish a relationship between the approach to participation and the level of outcome with respect to the three critical attributes of a successful development programme i.e. sustainability of the project, empowerment of citizens and learning for all the stakeholders involved. Sherry Arnstein in 1969 evolved the famous *ladder of participation* starting from non-participation to tokenism and finally empowerment. Herein, tokenism consists of citizens getting an opportunity to hear (sharing of information) and being heard (consultation) and even advice at certain times. But there is no scope of their voices being taken into consideration during decision-making. In the empowerment phase, citizens are given the power to influence the decision-making process by way of entering into a partnership with power holders, by way of delegation of powers and finally by way of completely controlling the entire decision-making process.

The World Bank (2007) observes that increased participation in planning can lead to formulation and investment in pro-poor policies, greater social consensus, and support for difficult policy reforms. According to its observation, experiences with Participatory Planning have shown positive links between participation, sound macroeconomic policies, and more effective government. For interventions regarding chronic disease treatment, effectiveness can require diagnostic accuracy, provider compliance with evidence-based treatment, 'continuity' of access by the patient, effective referrals and adherence to prescribed treatment and rehabilitation (WHO, 2002).

Attempts to address the problems regarding health service delivery focused on correcting the under-supply of health professionals, particularly physicians, in rural areas. Canadian report titled Toward Improved Access to Medical Services for Relatively Underserved Populations (Barer, Wood and Schneider, 1999) literally equates the improvement of access with increasing the number of doctors. However, it is increasingly being recognized that this is not a problem that can be treated in isolation, and that there needs to be a re-examination of the whole structure of how health services are delivered.

2.4.2 Participatory Planning and Accessibility to Health Care Services Delivered

Decentralization of social services, including health is embedded in the larger decentralization processes that are occurring in the Sub-Saharan Africa (SSA) region. Although the motives of decentralization differ across countries (Naidoo, 2002), the major arguments supporting decentralization in developing countries include economic and political gains. The economic justification for decentralization is allocative and productive efficiency aimed at improving public service delivery. Allocative efficiency involves better matching of public services to local

preferences, whereas productive efficiency involves increased accountability, fewer levels of bureaucracy, and better knowledge of local costs (Naidoo, 2002).

Prior to the 1990s, Uganda had a highly centralized healthcare system with considerable differences in health services standards between urban and rural areas (Jeppsson & Okuonzi 2000). After decentralization, the central government, through the Ministry of Health (MOH), is responsible for resource allocation and hospitals. However, it has devolved much of the responsibility of operating the lower health units, such as health centers and dispensaries, to lower levels of local government under the Ministry of Local Government. Health facilities run by faith-based organizations, which constitute 40 percent of the country's healthcare facilities, offer better services than non-faith-based facilities (Jeppsson & Okuonzi, 2000). Further, Jeppsson & Okuonzi (2000), existing data show no improvement in social services or people's quality of life during the period of the reform. In fact, many indicators have either remained the same or worsened.

Gaventa and Barrett (2010) find over 30 cases in which significant impacts were made in service delivery including in the health and education sectors. For example, in Brazil, they find out that the new participatory planning governance councils have been significant in improving timely access and quality of health care services. In Bangladesh, parents of girls in schools mobilized to undertake a participatory approach by monitoring teacher attendance and discouraging absenteeism. This technique registered timely access of students to their teachers and this ultimately improved the quality of teaching.

Gallivan, Utley and Jit (2002) discussed the heightened importance of length of staying variability in the context of United Kingdom government Initiative for hospitals to give a strong commitment to admitting a patient on a date arranged months in advance. They proposed analytical methods for estimating bed demand that incorporate empirical length of stay distribution. The time spent waiting can be psychologically painful because it causes the customer to give up more productive activities and increase the investment required to obtain a product or service. In addition, delay significantly influences the feelings of anger.

Mike, (1995) people are confronted with waiting for a variety of services in hospitals and the main source of wait is to be found in the conditions created by scarcity of resources. Time spent waiting is a resource investment by the patient for the desired aim of being seen by the physician and therefore may be moderated by the outcome. Gallivan, Utley and Jit (2002) individuals are forced to wait in order to have the desired service and they are ready to wait for a long time if that service is not readily available to them anywhere else. This situation may occur in various contexts including manufacturing; telecommunication, transport and heath care.

Klassen & Rohleder (2004), examine that in public hospitals, patients will usually carry on waiting in long queues seeking medical attention. This is usually due to the increased demand ahead of fewer or inadequate or limited suppliers of given resources. Many physicians are reporting to have insufficient time with patients due to the imbalance between the patients seeking medical care and physician capacity. One could attempt to explain this by suggesting an example of a popular physician who might only be able to consult with twenty patients per day whereas there might be thirty patients who have made an appointment to see him.

2.4.3 Participatory Planning and Quality of Services Delivered

Quality in the health context is referred to as a degree to which health services for individuals and populations increase the livelihood of desired health outcomes and are consistent with the current professional knowledge: Institute of Medicine (1990) as cited by Mclongline et al 2003.

Omaswa et al (1994) observes that access to health services is a good measure of quality healthcare. However access should be coupled with good interpersonal relations between the health provider and patients. Rude health workers make health services inaccessible to the patients, as they get scared away.

Armstrong (2000) defines quality as the degree of excellence achieved by an organization delivering products or services to its customers. Armstrong's definition however is narrow to be used in defining the concept of quality in relation to healthcare. The technical view of quality, looks at the extent to which services provided conform to pre-set minimum delivery standards.

The World Health Organization on the other hand defines quality health care as performance of interventions according to standards that are known to be safe, affordable and have ability to cause impact on mortality, mobility, disability and malnutrition (Lori 1999). These interventions can be include availability of drugs to treat ailments, availability of diagnostic equipment for health workers to use, clean and conducive environment for health workers to receive and treat patients and availability of protective wear to guard against risk of infections and injury.

Fabnoun and Chaker (2003), Health service quality is multi-dimensional. Beside medical care, patients need comfortable rooms, courteous and empathetic staff. Lochman (1998) mentioned the

importance of the interpersonal dimensions of health quality which is the main reason for medical litigations. Service quality is difficult to measure due to the unique features of services. Expectations are considered the standards that customers bring into the service experience. In other words, it is about what the customer believes should or will happen.

Akter, Upal and Hani, (2008) highlight that firms should not promise the customer more than the service the firm is capable of delivering. Organizations should work to close this gap which is very significant in delivering quality service. For that reason, it is difficult to find one common definition for the particular concept. It is a widely debated issue especially since it is so complicated to come to a unanimous agreement as to what exactly constitutes service quality.

Many definitions of service quality revolve around what is meant by service quality. Parasuraman et al. (1985) defined service quality as the differences between predicted or expected service (customer expectations) and perceived service (customer perceptions). "Expectations" refer to the customers' desire that they feel a service provider should offer. "Perceptions" are the customers' evaluation of the service provider.

Zeithaml, Bitner and Gremler (2006) establishes that service quality has been increasingly addressed and identified as the key factor in differentiating services and constructing competitive advantage and keeping a satisfying relationship with customers. Service quality can broadly be compared to the customer and how he or she feels about a service they received.

In a similar way, Babakus and Mangold (1992) analyzed the quality of health services basing on the capacity of hospitals in terms of their physical buildings, medical equipment, medical drugs

and sundries, beds and space in wards, as well as capability of the human resource providing healthcare services. They also analyzed the sufficiency, hygiene and the modernity of the buildings and equipment available in hospitals. Using such factors, Babakus and his associate drew conclusions on the quality of healthcare services delivered in hospitals to their clientele. All the parameters Babakus and Mangold (1992) used to assess healthcare quality service had budgetary execution complications in terms of construction, installation, stocking or meeting wage bills. However, Babakus and Mangold did not relate their perception to participatory planning.

Nguyen and Lassibille (2008), in an interesting examination of whether top down or bottom up participatory planning mechanisms work better, report on a random experiment in which different approaches were compared in schools in Madagascar. The findings showed that demand-led interventions led to significantly improved teacher behavior, improved school attendance and test scores compared to the top-down interventions which seemed to have minimal effects. It appears that although managers had better tools to hold lower level staff accountable, they were unlikely to do so without greater incentives. Similarly another random experiment in Kenya found that hiring contract teachers along with community monitoring along had significant impacts on student achievements.

In contrast, a widely cited study on citizen monitoring of road projects in Indonesia found that citizen monitoring had little average impact compared to increasing government audits (Olken 2007). If the expectations are higher than the performance level, then perceived service quality is less than satisfactory and that leads to customer dissatisfaction. Service quality is a multidimensional construct that is very difficult to evaluate due to the unique features of each of

the service provider (Zeithaml et al., 2006). However, simply creating decentralized structures or new procedures for participation in planning and administration does not guarantee that they will be effective or that they will generate greater economic growth or greater social equity. Neither do they necessarily imply greater democracy or a change in political and social power relationships (Naidoo 2002).

2.5 Summary of the Literature Review

This chapter discussed the views of different scholars with regard to the concept of participatory planning and health care service delivery (scope/coverage, timely accessibility and quality of services have an effect on service delivery). Health care services delivery is a great challenge in both developed and developing countries. The literature cited reveals that there are several factors that affect the delivery of health care services. In the literature review it is evident that the independent variable of this study, participatory planning could be having a bearing on the delivery of health care services in health facilities. There fore the need for carrying out a study to assess the extent to which participatory planning could be affecting delivery of health care services at Mulago Hospital.

Some of the gaps identified in the literature review revealed, there seems to be little research done on the variable in the study area, the researcher found no study conducted specifically about Participatory Planning and Healthcare Service Delivery at Mulago National Referral Hospital. Most studies on Healthcare Service Delivery were on other variables other than Participatory Planning denoting an opportunity to carry out this study whose findings would be very helpful in determining how involvement of stakeholders in goal setting, budgeting and formulation of targets affects delivery of healthcare services at Mulago Hospital.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the research design, study population, sample size selection, sampling techniques and procedures. It also presents data collection tools, the methods, data collection procedures, data analysis and measurement of variables.

3.2. Research Approaches

The study employed both qualitative and quantitative approaches of data management in order to complement each approach and authenticate the study. Qualitative and quantitative research were used to give emphasis to results from research questions, practical check for data collection and the need to understand one form of data before proceeding to the next stage Creswell, (2003). Qualitative research was used in describing processes to gather basic data and to find out what the major concerns are in the Health sector. Descriptive statistics were used for the quantitative analysis for prevalence, providing figures, sums and percentages for data analysis.

3.3. Research Design

The study adopted a descriptive survey and case study design to allow for in-depth data collection and analysis, contextual understanding and description of the research problem. The descriptive survey design is the most commonly used in social research. It allows collection of data once in the field from a sample of a population at a particular time and examining several variables at the same time (Amin, 2005). Correlation techniques were also used to measure the

relationship between participatory planning and service delivery management in Mulago Hospital.

3.4. Study Population

The target population of the study included top management staff, medical doctors, nurses/midwives and allied health professionals totaling to 1601 health medical workers at Mulago Hospital (Ministry of Health, 2009).

3.5. Sample Size Determination

A sample is a proportion of the population whose results can be generalized to the entire population. Using the Krejice and Morgan (1970), a total of 248 respondents was selected from 1601 Health workers to constitute a sample size from a target population of 1601.

Table 1 Distribution of the Sample Size and Selection

Category of Respondents	**Target Population**	**Sample Size**	**Sampling Techniques**
Administration	250	16	Purposive Sampling
Medical Department	788	152	Stratified, Simple Random & Convenient Sampling
Finance & Accounting	123	28	Stratified Sampling
Human Resource	20	11	Purposive Sampling
Procurement & Stores	420	41	Stratified & Simple Random Sampling
Total	**1601**	**248**	

Source: ***Primary Data*** **using** ***Krejice and Morgan (1970) Tables***

3.6 Sampling Techniques

Purposive sampling; these was used in the selection of Doctors, Pharmacists, Psychiatrists and Physiotherapists as study respondents. This technique was employed because the researcher presumed them to be highly conversant with the subject matter of study.

Stratified Random Sampling was also used in the selection of nursing officers and midwives. This aided to group some medical workers according to their respective sections/department. This technique led to the collection of diverse information or data with regard to the topic of study.

Convenient Sampling was mainly used in the selection of paramedics, and laboratory technicians. This technique made it possible to access the ever busy medics at Mulago Hospital; whose participation in the study would have been missed it other techniques of sampling were applied.

3.7 Sources of data Collection

Primary Source

This is data obtained from the actual field of study of study (Mulago Hospital). Primary data was gathered from respondents using a structured self-administered questionnaire and personal interviews. Depending on the accessibility of the respondent, some questionnaires were self-administered. The questionnaire consisted of mainly closed ended questions and a few open-ended questions for purposive clarity. The questionnaire was designed in accordance with the

study objectives. Quantitative data was got from the respondents' questionnaire while the qualitative data was got from Key Informant Interviews.

Secondary Source

This included data resources obtained by reviewing existing literature. These literature sources include but not limited to text books, academic journals, newspaper articles, the internet, and public/ private sector documents regarding participatory planning and service delivery. Secondary data was helpful in making the researcher broaden his understanding about the study concept, (Mugenda, and Mugenda, 1999)

3.8. Methods of Data Collection

3.8.1 Questionnaires

This involved collecting data using self administered structured questions that were designed prior to going in the field for data collection, (Amin, 2005). Questionnaires were both open and closed-ended in nature. Closed - ended questions were designed using a Five Point Likert Scale method, in order for respondents to easily rank their responses' with regard to order of importance for particular questions which were asked. Because of this, data collection and analysis became easy for quantification using frequencies, means and correlations.

3.8.2 Interview

An interview is a data collection method that a researcher uses to obtain data through oral communication and face to face interactions (McNamara, 2009). In respect to this, the researcher interviewed respondents with enriching information, which included, Doctors, pharmacists, psychiatrists, physiotherapists, and senior nurses among others. Interviews provides a more

realized presentation of what was on ground since you would easily spot out people's feelings and emotions regarding the subject matter. Secondly, detailed information from key personnel such senior Doctor and nurses was obtained using this method, (Mugenda & Mugenda, (1999).

3.9. Data Quality Control

To achieve quality results, data validity and reliability measurements were observed as follows:

Validity

To ensure validity, experts were consulted; principal supervisor, second supervisor, Mulago Hospital technical staff and colleagues in line with my academic field to design the instruments. Every objective and research question was considered with regard to the topic of the study while drafting instruments. A pilot study was carried out on a sample group of health workers within the hospital excluding the population that would be selected for the final study.

Reliability

This refers to the measure of the degree to which a research instrument yields consistent results or data after repeated trials (Mugenda & Mugenda, 1999). The reliability of questionnaires in relation to consistency of respondents' answers to all items in respect to the variables was tested and questions that were found unclear were corrected in order to get the right responses from the respondents. The purpose of this pre-test was to find out whether the instruments to be used were clear with no ambiguity. The purpose of this was to establish internal consistency of the data being used and to build confidence that was appropriate to produce good results. Using the SPSS software programme therefore, the Cronbach's alpha coefficient was tested to measure the

reliability of instruments, the average output statistic was 0.7. According to Amin (2005), an alpha of 0.5 or higher is sufficient to show reliability of the study.

3.10. Data Analysis

Data was analyzed both quantitatively and qualitatively. Quantitative data was edited, coded, and entered into the Statistical Package for Social Scientist (SPSS) system for tabulation and analysis. Using simple frequencies, percentage distributions, means, and standard deviations, the researcher described the extent of participatory planning and service delivery at Mulago Hospital. On the other hand, Qualitative data were analyzed thematically according to the objectives and research questions of the study. By grouping related data into themes, meaning was drawn and conclusions made with regard to peoples opinion, quotations, and the various documentations reviewed.

3.11. Ethical Considerations and Research Procedure

Introduction letter to conduct the study was sought from the Post Graduate School, Kyambogo University. Also permission was sought from Mulago Hospital administration to conduct the study and similarly consent had to be from respondents before administering the structured questionnaire. All the data was handled with confidentiality and only codes were used instead of names to ensure anonymity. Research assistants were trained on how the study was to be conducted noting down key issues of the interview. During the study, an introductory letter spelling out that the study was purely academic and appointments were scheduled to ensure adequate privacy to allow for respondents free expression.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 Introduction

This chapter presents the analyzed data from the field and gives interpretation of the study findings.

4.2 Basic Information on Respondents

Background information about respondents consist of their gender, age, level of education and designation in the organization as captured in table 2 as follows:

4.2.1 Gender of Respondents

Table 2 Disaggregation of Gender

Gender	Frequency	Percent
Male	143	57.6
Female	105	42.4
Total	**248**	**100.0**

Source: Primary Data

From Table 2, regarding Gender, majority of the respondents were male 148 (58%) while their female counterparts were 105 (42%). This implies that most respondents during the study were males as compared to females although Mulago Hospital employs more females than males.

4.2.2 Age of Respondents

Table 3 Age Distribution

Respondent's Age	Frequency	Percent
18-20	3	1.2
21-25	61	24.7
26-40	131	52.9
Above 40	53	21.2
Total	**248**	**100.0**

Source: Primary Data

Concerning age, Table 3 indicates that out of the 248 respondents who were examined, 131 were aged between 26 – 40 (52.9%), the age bracket of 21 – 25 (24.7%), above 40 years (21.2%) and 18 – 20 (1.2%). This implies that, most of the employees in Mulago Hospital are Youth between an age brackets of 21 – 40, thus energy and hard work towards completion of organization's goals.

4.2.3 Department of service for respondents in the Organization

Table 4 Department of service in the Organization

Department	Frequency	Percent
Administration	16	7
Medical Department	152	61
Procurement & Stores	41	17
Finance & Accounting	28	11
Human Resource	11	4
Total	**248**	**100.0**

Source: Primary Data

Pertaining to departments at Mulago Hospital, Table 4, majority of the respondents were from the medical department 152 (61%), followed by procurement and stores department 41 (17%), financial and accounting 28 (11%), administration 16 (7%), and lastly, human resource department 11 (4%). This signifies that the biggest number of employees at Mulago Hospital is medical staff handling health care and treatment of clients.

4.2.4 Level of Management in the Organization

Table 5 Level in the Organization

Level	Frequency	Percent
Top Mgt	26	11
Middle Mgt	63	25
Lower Mgt	159	64
Total	**248**	**100.0**

Source: Primary Data

In reference to Table 5 pertaining to level of management in the organization, a bigger number of respondents were from lower management 159 (64%), followed by middle management 63 (25%) and finally top management with 26 (11%). From findings, majority of respondents constituted lower level of management followed by middle and top management levels respectively which affects decision making at Mulago Hospital.

4.2.5 Level of Education

Table 6 Level of Education of the Respondents

Level of Qualification	Frequency	Percent
Certificate	32	12.9
Diploma	99	40.0
Bachelor's Degree	61	24.7
Masters Degree	41	16.5
PhD	3	1.2
Other	12	4.7
Total	**248**	**100.0**

Source: Primary Data

From table 6, it is indicated that, majority of the respondents were diploma holders 99 (40%), followed by those with Bachelor's degrees 61 (24.7%), then Master's degree holders 41 (16.5%), Certificate holders 32 (12.9%), PhD holders 3 (1.2%), and those with other qualifications 12 (4.7%). Results of the study illustrate that Majority of hospital staffs have undergone professional training in health care. This implies that the high education standards and professional training of staff could positively contribute to delivery of health care services.

4.3 Research Questions used:

To have the Research Questions answered, a series of questions were asked. Results pertaining to participatory planning are presented in Table 7 as follows:

Table 7 Responses on Participatory Planning:

Indicate the extent to which you agree or disagree with the statement that:	**Mean**	**SD**
The Planning Agents of the hospital where you serve accord chance to clients to identify their needs which the hospital has to address.	2.65	1.043
The management of the hospital where you serve collaborates with stake holders during goal setting stage for planning for activities to be embarked on.	2.86	.833
Stakeholders of the hospital where I serve are empowered to take part in goal setting when planning for activities to be pursued.	2.66	.810
Planning Agents of the hospital where you serve involve hospital clients to reach consensus in setting priority needs to which the hospital has respond.	2.32	.848
Management of the hospital where you serve holds frequent consultative meetings with hospital stakeholders to plan the activities of the hospital.	2.60	.876
Management of the hospital where you serve encourages active participation of different stakeholders in planning hospital activities.	2.56	.932
The management of the hospital where you serve sets objectives basing on the expressed needs of the hospital clients.	2.52	.971
Average Mean	**2.59**	

Source: Primary Data

Table 7, indicates a low average mean of 2.59 with regard to participatory planning in Mulago Hospital. This was attributed to the low levels of responses on the issues of; the hospital

management collaborating with stake holders during goal setting for planning of activities which are to be embarked on (mean = 2.86), followed by stakeholders of the hospital being empowered to take part in the goal setting process (mean = 2.66), planning agents at the hospital accord chance to clients to identify their needs for the hospital to address (mean = 2.65), management of the hospital hold frequent consultative meetings with hospital stakeholders to plan for activities of the hospital (mean = 2.60), hospital management sets objectives basing on the expressed needs of the hospital clients (mean = 2.56), hospital management encourages active participation of different stakeholders in planning process (mean = 2.52), and last, hospital planning agents involve its clientele in consensus when setting priority needs of the hospital (mean = 2.32).

Table 8 Correlation Analysis of Participatory Planning and Total Service Delivery

Variables Correlated	r-value	Sig.
Extent of Participatory planning and total service delivery management	.471	.000

Source: ***Primary Data***

Table 8 shows results of the main objective of the study, which was to examine the relationship between participatory planning and total service delivery management in Mulago Hospital. Results show a positive and significant relationship of (r = .471, and Sig. 0.000) between participatory planning and service delivery in Mulago Hospital obtained using Pearson Correlation Coefficient (PLCC). The result implies that, participatory planning relate with service delivery by 0.471, and that, the other factors/ intervening variables such as resource availability (not researched on), contribute 52.9% in service delivery performance at Mulago Hospital.

4.3.1 Research Question One: "To what extent does participatory planning relate to scope (coverage) of health care services delivered to clients of Mulago Hospital?"

Research Question One focused on the relationship between Participatory Planning and scope (coverage) of services delivered to clients of Mulago Hospital. To have the Research Question answered, a series of questions were asked. Results concerning Research Question One are presented in Table 9 as follows:

Table 9 Scope of Service Delivery Management

Indicate your level of agreement or disagreement with the following statements:	**Mean**	**SD**
Varieties of medical services are offered at the hospital where you serve.	3.92	.759
Most of the medical services offered at the hospital where you serve are easily accessed.	3.07	.768
I am satisfied with the number of services offered to hospital clients in the hospital where I serve.	2.87	.884
Medical services offered at the hospital where I serve are adequate.	2.81	.919
I am comfortable with the way medical services are offered to hospital clients in the hospital where I serve.	2.75	.858
Average Mean	**3.08**	

Source: Primary Data

Table 9 presents findings on the level of scope as a dimension of service delivery management. Result indicated a moderate extent of scope of average mean of 3.08. This was attributed to

moderate responses on the issues of; hospital offering a variety of medical services (mean =3.92), easy accessibility of medical services offered by the hospital (mean =3.07), employee being satisfied with the number of services offered to clients by the hospital (mean =2.87), adequacy of medical services offered by the hospital (mean =2.81), and lastly, employees being comfortable with the way medical services are offered to clients by the hospital (mean = 2.75)

Table 10 Correlation Analysis of Participatory Planning and Scope of Service Delivery

Variables Correlated	r-value	Sig.
Participatory planning and the scope of delivery of Health Care Services	.277	.010

Source: Primary Data

Concerning the relationship between participatory planning and the scope (coverage) of services delivered to clients of Mulago Hospital in Uganda, the study revealed a relatively high positive relationship between the two variables (r = 0.277 and Sig. 0.010). This implies that, whenever Mulago Hospital invests in participatory planning, the coverage of service delivery is affected by 27.7 percent, which is quite significant in terms offering services within the hospital, since a substantial numbers of patients get to benefit. The result implies that participatory planning relate with scope of service delivery by 0.471, and that, the other factors/ intervening variables such as resource availability (not researched on), contribute 52.9% in coverage of service delivery at Mulago Hospital.

4.3.2 Research Question Two: "What is the relationship between participatory planning and timely accessibility to health services offered at Mulago Hospital?"

Research Question Two emphasized the relationship between Participatory Planning and Timely Delivery of Services to clients of Mulago Hospital to counter the Research Question, a number

of questions were asked. Results regarding Research Question Two are presented in Table 11 as follows:

Table 11 presents the descriptive results about timely delivery of services

Indicate the extent to which you agree or disagree with the statement that:	**Mean**	**SD**
Medical services offered in the hospital where I serve are timely delivered to hospital clients.	2.80	.753
Clients of the hospital where I serve get better guidance about when to get treated.	2.98	.740
A number of clients leave the hospital where I serve after being attended to in good time.	2.62	.771
Complaints of hospital clients where I serve are addressed in good time.	2.62	.816
The hospital where I serve delivers services quickly to hospital clients.	2.58	.777
Average Mean	**2.72**	

Source: Primary Data

Table 11 indicates a moderate level of timely delivery of services at Mulago Hospital with an average mean of 2.72, interpreted as undecided. This moderate results are mainly brought about by moderate responses on the issues of; offering guidance to clients by the hospital whenever they come for treatment (mean = 2.98), followed by timeliness of offering medical services by the hospital to its clients (mean = 2.80), most client leave hospital when attended to (mean =2.62), hospital delivering services to clients in time (mean = 2.62), and lastly, hospital addressing complaints logged in by its clients in time (mean = 2.58)

Table 12 Responses on Timely delivery of Medical Services offered in the Hospital

To what extent are you satisfied with the following	Mean	SD
Time for making appointment to see medical personnel.	3.05	.615
Time taken to get admitted to the hospital.	3.06	.696
Time taken to be attended to when admitted in the hospital.	3.00	.655
Time taken to get discharged from the hospital.	2.86	.758
Average Mean	**2.99**	

Source: Primary Data

Table 12 shows results on level of timely service delivery management by Mulago Hospital. Finding indicates that majority of the respondents were undecided with an average mean of 2.99. This was caused by low responses on the time taken to get admitted in the hospital (mean = 3.06), followed by time for making appointment to see medical personnel (mean =3.05), time taken to be attended to when admitted in the hospital (mean = 3.00), and lastly, time taken to be discharged from the hospital (mean = 2.86)

Table 13 Correlation Analysis of Participatory Planning and Timely Delivery Services

Variables Correlated	r-value	Sig.
Participatory planning and timely service delivery	.289	.007

Source: Primary Data

Concerning participatory planning and timely service delivery management, in Table 13 the study indicated a positive and significant relationship of (r = 0.289 and Sig. = 0.007). This implies that, participatory planning fairly affects service delivery management in terms of time and that their relationship is relative significant. This could possibly be resulting from the fact that, complaints by the hospital clients being addressed on time, which enables to plan for such

factors that could probably be leading to inefficiencies in time management during the service delivery process.

4.3.3 Research Question Three: "Does participatory planning influence quality of service delivery in Mulago Hospital?"

Research Question 3 looked at the relationship between Participatory Planning and Quality of Services Delivery to clients of Mulago Hospital. To address the Research Question, several questions were asked and results on the Question subject to Research are obtainable in Table 14 as follows:

Table 14 Quality of Services Delivery

	Mean	**SD**
Medical services offered at your hospital of service are of acceptable standard.	3.47	.946
The clients (patients) of the hospital where you serve are satisfied with medical services offered.	3.00	.577
The quality of services offered by the hospital where you work is excellent.	2.94	.761
The services offered to hospital clients where you work are fully satisfying their expectations.	2.86	.693
The hospital where I serve makes an annual quality improvement plan for the services offered to the hospital clients.	2.80	.753
Average Mean	**3.01**	

Source: Primary Data

Table 14 presents results on the level of quality service delivery by Mulago Hospital. It indicates a moderate level of quality service delivery management with an average mean of 3.01. This was attributed to average responses on the issue of; medical services being of acceptable standards at the hospital (3.47), followed by hospital clients being satisfied with medical services offered by the hospital (3.00), excellent services offered by the hospital (2.94), and lastly, the hospital making annual quality improvement plan to enhance on the services offered to its clients (2.80)

Table 15 Correlation Analysis of Participatory Planning and Quality of Service Delivery

Variables Correlated	r-value	Sig.
Participatory planning and quality of service delivery	.567	.000

Source: Primary Data

In Table 15, the study further reveals that, participatory planning and the quality of service delivery specifically, contributes more than any other construct under service delivery management by (r = 0.567, and Sig. value 0.000). This concurs with the Systems Participative Theory (1983) that, participatory planning greatly influences quality services delivered. The involvement of people in the planning process allows them to better define their needs, which then enhances quality management, since quality is all what best fits, (Humphreys, & Morris, 1998).

CHAPTER FIVE

DISCUSSIONS, SUMMARY, CONCLUSIONS, & RECOMMENDATIONS

5.1 Introduction

This chapter presents a discussion of the study finding, the associated summary, conclusions, recommendations and areas for further research. This is as follows;

5.2 Discussion

5.2.1 Participatory Planning and Service Delivery

Findings indicated that, participatory planning in Mulago Hospital with an average mean of 2.9. When this was correlated against service delivery, which was also moderate at an average of 2.94, a significant and a moderate relationship of (r = .471, and Sig. 0.000) was indicated between participatory planning and service in Mulago Hospital. This implies that, participatory planning neither service delivery is high at Mulago Hospital. They are rather moderate. This result depicts the Health Sector Strategic Plan III, which indicates that Mulago is highly limited with information. This is attributed to the limited engagement of key stakeholders, in particular the public regarding planning process of the Hospital. The public sector is a dominant player in the operation of public sector organization like Mulago Hospital (EPRC, 2010). In light of this, managers are therefore encouraged to engage their clientele as key players in the planning process in order to service them better.

5.2.2 Participatory Planning and Coverage in Service Delivery

A moderate level of coverage or scope of delivery service was indicated in Mulago Hospital with an average mean of 3.08. When participatory planning (average mean = 2.90) was correlated

against coverage of service delivery, a positive and significant result of (r value = 28% and Sig. = 0.010) was indicated. This result depicts a low level of contribution coverage in service delivery by participatory planning. This concurs with Goncalves, (2013) in his study on the effects of participatory budgeting on municipal expenditures and infant mortality in Brazil and found out a positive relationship between participatory planning in budgeting and the extent or scope at infant mortality was mitigated. Similarly, scholar like Besley et al. (2005), Brett (2003), Sousa and Santos (1998) contend towards the contribution of participatory planning and extent of service coverage. Although this relationship was a little marginal in Mulago its imperative to note that the relationship follows a positive direction. Managers therefore need to ensure that a substantial number of stakeholders from a wide geographical area are involved in order to achieve a relatively wide coverage in terms of service delivery performance.

5.2.3 Participatory Planning and Time Management in Service Delivery

Results reveal that time management in service delivery at Mulago Hospital was moderate at average mean of 2.72. This was correlated against participatory planning (average mean = 2.90) whereby a positive and significant result was showed (r value = 29% and Sig. = 0.010). Although the relationship was a little low, it was positive and significant, and that effect management of participatory planning contributes to timely management at a margin of 29%. This is sufficient to foster organizational efficiency and thus realization of organizational goals. This concurs with Shah (2007) who analyzed the effect of participatory budgeting on public sector performance with bias on governance and accountability and concluded that participatory planning is crucial in achieving timelines in service delivery performance. Similar thoughts are shared by scholar like, Wampler, (2004), and Besley et al. (2005).

5.2.4 Participatory Planning and Quality of Service Delivery

Findings indicated a moderate extent of quality management in service delivery at Mulago Hospital with an average mean of 3.01. This was then correlated against participatory planning (average mean = 2.90) and it was revealed that participatory planning highly relates with quality management in service delivery (r value = 57% and Sig. value = 0.00). This is in agreement with majority of the scholars who have analyzed the influence of participatory planning on organizational performance. For instance, scholars like Oakley (1991), Goncalves (2013), Mansuri & Rao (2012) all contend towards this thought. Worth noting is that, achieving quality is one of the most cardinal goal that any organization would yarn for. Akao (1990) maintains that the use of tools like; quality functional deployment, fishbone diagrams, and problems tree is one way of engaging stakeholders, particularly the consumers in which organizational can use to achieve effective quality management. Managers therefore ought to borrow a leaf from such studies in order to enhance operational efficiency.

5.3 Summary

5.3.1 Participatory Planning and Service Delivery

A low extent of participatory planning in Mulago Hospital was indicated with an average mean of 2.9, which was correlated against service delivery (average mean = 2.94) whereby a positive and significant relationship of (r = .471, and Sig. 0.000) was indicated between participatory planning and service in Mulago Hospital. This relationship was interpreted as moderate, and that managers need to invest more in participatory practices given their effect on service delivery.

5.3.2 Participatory Planning and Coverage in Service Delivery

A moderate level of coverage or scope of delivery service was indicated in Mulago Hospital with an average mean of 3.08. When participatory planning (average mean = 2.90) was correlated against coverage of service delivery, a positive and significant result of (r value = 28% and Sig. = 0.010) was indicated.

5.3.3 Participatory Planning and Time Management in Service Delivery

Results also reveal a moderate extent of time management in service delivery at Mulago Hospital with an average mean of 2.72. This was correlated against participatory planning (average mean = 2.90), whereby a positive and significant result was showed (r value = 29% and Sig. = 0.010).

5.3.4 Participatory Planning and Quality of Service Delivery

A moderate extent of quality management in service delivery was indicated generally in Mulago Hospital with an average mean of 3.01. This was then correlated against participatory planning (average mean = 2.90) and it was revealed that participatory planning highly relates with quality management in service delivery (r value = 57% and Sig. value = 0.00).

5.4 Conclusion

From the findings of the study the researcher draws the following conclusions; (1) there is a significant relationship between participatory planning and the scope (coverage) of service delivery in Mulago Hospital; (2) there is a significant relationship between participatory planning and timely accessibility of health services offered by Mulago Hospital; (3) there is a significant relationship between participatory planning and the quality of services delivered by Mulago

Hospital. That notwithstanding, the study revealed a significant relationship between participatory planning and health service delivery in general at Mulago Hospital. Basing on these findings therefore, managers ought to accord a significant amount of attention in ensuring that all stakeholders are involved in the planning process of an organization; in this way, effective service delivery will be realized.

Despite government's allocation of more funds to the health sector, there has been no improvement health care services or people's quality of life. Many indicators seem to have either remained the same or worsened. Factors responsible include weak financial resource management and allocation patterns at the local level that prioritize private benefits of staff, as opposed to investment in services of a public nature; another factor involves shortcomings in personnel quality and management. In general, decentralization of health services has not resulted in greater participation of the ordinary people and accountability of service providers to the community.

5.5 Recommendations

Basing on conclusion the study findings, the recommendations are:

1. There is need for each and every department within the Hospital to institute a data collection, analysis and dissemination mechanism in order to formulate intervention strategies to address the various medical cases that come across. The participation of the different department within the hospitals helps forge a comprehensive atmosphere that promotes a wide coverage in data collection and dissemination across the hospital thus effective service delivery management.

2. The hospital needs to inculcate a spirit of teamwork among its staff members, especially those in the line of duty. For example, in situations where patients are assigned to specific doctors they tend to be put on hold unless they have consulted the doctor in-charge. This puts life of patients in danger since they take long to be attended too during consultation from the doctor in-charge.

3. The hospital should ensure joint planning with service providers like the National Medical Stores. This will enhance timely service delivery management of drugs within the hospital. Problem of shortages, over stocking and expiry of drugs will be minimized as a result of such collaborating planning between Mulago and its service providers.

4. There is need for sufficient communication systems in order to promote effective information flow within the hospital. These will help expedite internal operations by keeping all stakeholders updated with relevant at all times, hence effective decision making and improved service delivery.

5.6 Areas for further research

The researcher recommended the following areas for further research:

1. A future research could conduct a comparative study of public and private hospitals to enhance our understanding and knowledge on healthcare service delivery in Uganda.
2. Strategic planning and the performance of Local Government entities in Uganda.
3. Determinants of effective public finance management among public sector organisations in Uganda

REFERENCE

Akter, S., Upal, M. & Hani, U. (2008) 'Service Quality Perception and Satisfaction: A Study Over Sub-Urban Public Hospitals in Bangladesh': *Journal of Service Research of Institute for International Management and Technology*, Special Issue, p.125-146

Akao,Y. (1990), Quality Function Deployment: Integrating Customer Requirement Into Product Design : Cambridge

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

Arnstein, S. R. (1969). A Ladder of Citizen Participation, *Journal of the American Institute of Planners*, *35*(4), 216–224.

Armstrong, M. (2000), Performance Management, Kogan Page Ltd

Babakus, E. and Mangold, W.G. (1992) "Service quality in hospitals: An empirical investigation" *Health Services Research* 26, 767-786

Barer, M. L, Wood. L, Schneider. D. G. (1999) Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons. Centre for Health Services and Policy Research. The University of British Columbia

Barnum, H. and J. Kutzin (1993): "Public Hospitals in Developing Countries: Resource Use, Cost, Financing," *John Hopkins University Press*: Baltimore, Maryland.

Besley, T, Rohini, P, Lupin, R and Vijayendra R. (2005) "The politics of Public Good Provision: Evidence from Indian Local Government", Journal of the European Economic Association, Volume 2-23, 2004

Bhatnagar, B, Aubrey C. W, (1992) *Participatory Development and the World Bank: Potential Directions for Change*, Washington, D.C.: World Bank Publications

Brett, E. A. (2003) Participation and accountability in development management, Journal of Development Studies, 40(2), pp. 1–29

Buhaug, H. (2002) 'Long waiting List in Hospitals: Operational research needs to be used more often and may provide answers'. *British Medical Journal*, Vol. 324, pp.252-253

Cornwall, A. (2002) 'Making Spaces, Changing Places: Situating Participation in Development', *IDS Working Paper 170*, Brighton, CDRC, IDS.

Craig, G. and Mayo, M. (1995) Editorial Introduction: Redesigning Community Development: Some prerequisite for working in and against the state. Community Development Journal 30 (2): 105-9

Crenson, M, and Ginsberg, B, (2002) *Downsizing Democracy: How America Sidelined its Citizens and Privatized its Public*, Baltimore: John Hopkins University Press

Creswell, J. (2003) *Research Design. Qualitative, Quantitative and Mixed Methods Approaches* (2nd ed.), Sage, Thousand Oaks

De Man, S.,Vandaele, D. & Gmmel, P. (2004) 'The waiting experience and consume perception of service quality in outpatient clinics'. Working paper of Faculty of Economics and Business Administration, Ghent University

Economic Policy Research Centre, (EPRC) (2010) *Governing Health Service Delivery in Uganda: A tracking Study of Drug Delivery Mechanisms.* Research report

Ennis K., Harrington D. (2001) Quality Management in Irish Health Care *The Service Industries Journal* 21(1) 149-168

Eyben, R. (2003) 'The Rise of Rights', IDS Policy Briefing, Issue 17

Fabnoun, N. & Chaker, M. (2003) 'Comparing the Quality of Private and Public Hospitals' *Managing Service Quality*, Vol. 13, Issue 4

Fisher, R., Ury W, & B. Patton (1991) *Getting to yes: Negotiating agreement without giving in.* Penguin Books: New York. 200 p

Folkes, V.S. (1988), "Recent attribution research in consumer behaviour: a review and new directions", *Journal of Consumer Research*, Vol. 14, March, pp. 548-65.

Gallivan, S., Utley M. and Jit, M. (2002), Health Operations Management, Patient Flow Logistics in Health Care, MPG Books Ltd, Bodmin, Great Britain

Gaventa, J. and Barrett, G. (2010) 'So What Difference Does it Make? Mapping the Outcomes of Citizen Engagement', *IDS Working Paper* 348, Brighton: Institute of Development Studies.

Goncalves, S., (2013). The Effects of Participatory Budgeting on Municipal Expenditures and Infant Mortality in Brazil, *World Development,* Vol. XX, pp. xxx–xxx, http://dx.doi.org/10.1016/j.worlddev.2013.01.009

Hubbard, G,_Kidd, L, Donaghy, E, McDonald, C, Kearney, N, (2007) A review about involving people affected by cancer in research, policy and planning and practice, *Patient Education and Counseling,* 65, 21-33.

Jeppsson, A, and Okuonzi S. A, (2000). Vertical or holistic decentralization of the health sector? Experiences from Zambia and Uganda, *International Journal of Health Planning and management* 15: 273–289.

Karuneri (2011) *Project: improvement of health services delivery at mulago hospital.*

Kaseje, D. (2006). Health Care in Africa: Challenges, Opportunities and an Emerging Model for Improvements.

Kaufman R, Hugh O.B, Watkins R, Leigh D 1998, Strategic Planning For Success: Aligning People, Performance, and Payoffs

Klassen, K.J. & Rohleder, T.R. (2004) 'Outpatint Appointment Scheduling with Urgent Clients in a Dynamic, Multi-Period Environment': *International Journal of Service Industry Management*, Vol. 15, Issue 2, p.167-174

Krejice. R.V and Morgan D.W (1970) Determining Sample Size for Research Activities: *Educational and Psychological Measurement* 30, pp. 607-610

Kuye J.O, (2007) African Journal of Public Affairs: The African Consortium of Public Administration, University of Pretoria: South Africa

Lochman, j. E (1998) "factors related to patients` satisfaction with their medical care". *Journal of Community Health*, vol.9, Issue 2, pp. 91-108.

Manor, J. (2004) 'User committees: a potentially damaging second wave of decentralization?', *European Journal of Development Research*, 14 (2).

Mansuri, G, and Rao, V, (2013) Localizing Development, Does Participation Work: Washington D.C

Mike, H. (1995) 'Improving out-Patient Clinic Waiting Times: Methodological and Substantive Issues'. *International Journal Of Health Care Quality Assurance*, Vol. 8, Issue 6, P.14

Ministry of Health (2009), National Health Policy of Uganda: Reducing poverty through promoting people's health

Ministry of Health Audit Report (2006). Kampala, Uganda

Moore M and Benington J (2010, in press): Public Value: Theory and Practice, London, Palgrave.

Moore, M. (1995) Creating Public Value: Strategic Management in Government, Cambridge,

Mowen, J.C, Licata, J.W & McPhail, J. (2002) 'Waiting in Emergency Room: How to Improve Patient Satisfaction'. *Journal of Health Care Marketing*, Vol. 16, Issue 3, p.26-32.

Mugenda, M. Olive and Abel G. Mugenda (1999) Sample size: *Research Methods Quantitative and Qualitative Approaches,* Kenya African Center for Technical Studies (ACTS)

Mutabwire, P, (2006) Strengthening Competencies for Participatory *Planning and Planning for Effective Local Level Delivery of Services;* Participatory Health Service Delivery: The fight against HIV/AIDS in Uganda: Manthabiseng Convention Center, Maseru, Kingdom of Lesotho.

Naidoo R. (2002) Corporate Governance: An Essential Guide for South African Companies: Juta and Company Ltd, Cape Town.

Nguyen, T. and Lassibille, G. (2008) "Improving Management in Education: Evidence from a Randomized Experiment in Madagascar." Draft paper from JPAL website

Nkata, J.L, (2006) A Road Map to Participate in Management of Education Institutions: *Theories and Concepts.* Kampala Makerere University

Oakley, P, (1991) *Projects with People: The practice of participation in rural development.* International Labour Office: London

Omaswa, F.G.et al (1994) Quality Assurance for Health workers in Uganda, A manual for Quality Improvement Methods

Parasuraman, A., Zeithaml, V.A. & Berry, L.L. (1985) 'A Conceptual Model of Service Quality and its Implications for Future Research': *Journal of Marketing*, Vol. 49, Issue 4, Pp.41-50

Rahman, A & Kabir M (2004), 'Session 5: Introduction to Participatory Budgeting', in *Output Oriented Budgeting, the Poor and Gender*, Module 6

Scolum, N. (2003). *Participatory Methods Toolkit, A practitioner's Manual.* King Baudouin Foundation. Belgium

Schirnding Y.V (2002) Health In Sustainable Development Planning: The Role Of Indicators

Sebenius J.K. and Lax D.A, (2006), 3-D Negotiation: Powerful Tools to Change the Game in Your Most Important Deals, Harvard University Press: Boston

Sewankambo N.K, (2008) The Value and Challenges of Institutional Partnerships in Global Health a view from the South, Makerere University: Uganda

Shah A (2007) Public Sector Governance and Accountability Series: Participatory Budgeting, Washington D.C

Shankland, A, 2005, 'Speaking for the People: Representation and Health Policy Processes in the Brazilian Amazon', paper for DPhil Research Outline Seminar, IDS

Shmueli D.F, Kaufman. S & Ozama C. (2005) Mining Negotiation Theory for Planning Insights: Journal of Planning education and research. Association of Collegiate Schools of Planning: http:urban.csuohio.educ/sanda/paper/mining.pdf. (6th.05.14)

Spoelstra M & Pienaar W. (1996) *Negotiation: theories, strategies and skills.* Kenwyn

Sousa Santos, Boaventura, D. (1998) "Participatory Budgeting in Porto Alegre: Toward a Redistributive Democracy," *Politics & Society*, 26:4

Stein, J. (1997). Empowerment and Women's Health: Theory, Methods and Practice. London: Zed Books Ltd, pp. 60 – 65.

Suzzane H.B, (1998). *Qualitative Research and Case Study Application in Education:* Jossey Bass Publishers, San Francisco

Tandon, R, (2005). Participatory Research, Revisiting the Roots: New Delhi: Mosaic Publications

Taylor, P. and J. Fransman (2004), "Learning and teaching participation: exploring the role of higher learning institutions as agents of development and social change", working paper 219, Falmer, Institute of Development Studies.

Tusiime, H.M. (2012). Technology of Research and Grant Proposal Writing: *A Step-by-Step Guide to Proposal Formulation:* LAP Lambert Academic Publishing. Deutschland, Germany

Truong V. T. (2004). Participatory planning for resource governance in Tam Giang lagoon

United Nations Development Programme (1997): Who are the Question makers? A Participatory Evaluation Hand Book, Office of Evaluation and Strategic Planning.

Wampler, B. (2004) "Expanding Accountability through Participatory Institutions: Mayors, Citizens, and Budgeting in Three Brazilian Municipalities." *Latin American Politics and Society* 46:73-100

World Health Organization, (2008) Integrated Health Services – What and Why? Making Health Systems Work *Technical brief No.1* World Health Organization, Geneva

World Bank Annual Report, (2007)

World Health Organization Report (2004) Changing history for a comprehensive HIV/AIDS strategy that links prevention, treatment, care and long-term support

World Health Organization Report (2002) Reducing Risks, Promoting Healthy Life

World Health Organization, (2000) *World Health Report.* Geneva: Switzerland.

World Health Organization (1999) *Ottawa Charter for Health Promotion.* World Health Organization, Geneva.

World Health Organization (1997) *Jakarta Declaration on Leading Health Promotion into the 21st Century:* World Health Organization, Geneva

Youssouf, M (2009) *Improvement of Health Services at Mulago National Referral Hospital and the city of Kampala.* Project Preparation facility.

Zeithaml, V.A., Bitner, M.J & Gremler, D.D (2006) *Services Marketing: Integrating Customer Focus Across the Firm*: McGraw Hill, New York.

APPENDIX A

Questionnaire

Introduction

This is a questionnaire for a study on Participatory planning and service delivery in public hospitals in Uganda. You have been selected to participate because you are deemed to have the information needed for the study. The information you give is purely for academic purposes and no participants name will be mentioned during report writing. You are requested to choose the answer that most suits your level of agreement or disagreement with the question.

PART 1: DEMOGRAPHIC & BACKGROUND DATA

1. Gender: Male ☐ Female ☐

2. Age of the Respondent

   18 – 20 ☐ 2. 21 – 25 ☐ 3. 26 – 40 ☐ 4. Above 40 ☐

3. What is your current level of education?

   Certificate ☐ Diploma ☐ Bachelor's ☐ Masters Degree ☐

   PhD ☐ Other ☐

4. What is your current position

   Senior ☐ Middle level ☐ Lower Level ☐

PART 2: PARTICIPATORY PLANNING

Indicate your level of agreement or disagreement with the following statements on participatory planning using the following responses: 1. Strongly Disagree (SD) 2. Disagree (D) 3. Not Sure (NS) 4. Agree (A) 5. Strongly Agree (SA)

Indicate the extent to which you agree or disagree with the statement that:	**SD**	**D**	**NS**	**A**	**SA**
1. The Planning Agents of the hospital where you serve accord chance to clients to identify their needs which the hospital has to address.	1	2	3	4	5
2. The management of the hospital where you serve collaborates with stake holders during goal setting stage for planning for activities to be embarked on.	1	2	3	4	5
3. Stakeholders of the hospital where I serve are empowered to take part in goal setting when planning for activities to be pursued.	1	2	3	4	5
4. Planning Agents of the hospital where you serve involve hospital clients to reach consensus in setting priority needs to which the hospital has respond.	1	2	3	4	5
5. Management of the hospital where you serve holds frequent consultative meetings with hospital stakeholders to plan the activities of the hospital.	1	2	3	4	5
6. Management of the hospital where you serve encourages active participation of different stakeholders in planning hospital activities.	1	2	3	4	5
7. The management of the hospital where you serve sets objectives basing on the expressed needs of the hospital clients.	1	2	3	4	5

Q8. Suggest some ways in which the management of the Hospital where you serve can enhance participation of different stakeholders in the planning process.

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Q9. Using your experience at the hospital where you serve, please indicate the different ways in which the different stakeholders are involved in the planning process of the hospital activities.

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PART 3: SCOPE OF SERVICE DELIVERY

Indicate your level of agreement or disagreement with the following statements on service delivery using the following responses:

1. Strongly Disagree (SD) 2. Disagree (D) 3. Not Sure (NS) 4. Agree (A) 5. Strongly Agree (SA)

Indicate your level of agreement or disagreement with the following statements:	**SD**	**D**	**NS**	**A**	**SA**
1. Varieties of medical services are offered at the hospital where you serve.	1	2	3	4	5

2. Most of the medical services offered at the hospital where you serve are easily accessed.	1	2	3	4	5
3. I am satisfied with the number of services offered to hospital clients in the hospital where I serve.	1	2	3	4	5
4. Medical services offered at the hospital where I serve are adequate.	1	2	3	4	5
5. I am comfortable with the way medical services are offered to hospital clients in the hospital where I serve.	1	2	3	4	5

Q6. Suggest some ways through which the management of the hospital where you serve can boost the coverage of the services offered to hospital clients.

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Q7. Indicate the areas in which you are satisfied with the medical services offered by the hospital where you serve.

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Q8. Please explain why you are satisfied with the way medical services are provided to hospital clients of where you are serving.

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Q9.Indicate areas of medical service provision offered to clients that you might not be satisfied with at the hospital where you serve.

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PART 4: TIMELY DELIVERYOF SERVICES

Indicate your level of agreement or disagreement with the following statements using the following responses:

1. Strongly Disagree (SD) 2. Dissagree (D) 3. Not Sure (NS) 4. Agree (A) 5. Strongly Agree (SA)

Indicate the extent to which you agree or disagree with the statement that:	**SD**	**D**	**NS**	**A**	**SA**
1. Medical services offered in the hospital where I serve are timely delivered to hospital clients.	1	2	3	4	5
2. Clients of the hospital where I serve get better guidance about when to get treated.	1	2	3	4	5
3. A number of clients leave the hospital where I serve after being attended to in good time.	1	2	3	4	5
4. Complaints of hospital clients where I serve are addressed in good time.	1	2	3	4	5
5. The hospital where I serve delivers services quickly to hospital clients.	1	2	3	4	5

Indicate your level of satisfaction or dissatisfaction with the time taken on the following items using the responses:

1. Very Satisfied (VS) 2. Satisfied (S) 3. Not Satisfied (NS) 4. Somewhat Satisfied (SS) 5. Not Satisfied at All (NSA)

To what extent are you satisfied with the following	**VS**	**S**	**NS**	**SS**	**NSA**
1. Time for making appointment to see medical personnel.	1	2	3	4	5
2. Time taken to get admitted to the hospital.	1	2	3	4	5
3. Time taken to be attended to when admitted in the hospital.	1	2	3	4	5
4. Time taken to get discharged from the hospital.	1	2	3	4	5

Q5. Suggest some ways through which the hospital where you serve can enhance timely delivery of Medical services offered to Hospital clients (patients).

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PART 5: QUALITY OF SERVICES DELIVERED

Please tick or circle the response that most closely describes how much you agree or disagree with the following statements:

Indicate the extent to which you agree or disagree with the statement that:	**SD**	**D**	**NS**	**A**	**SA**
1. Medical services offered at your hospital of service are of acceptable standard.	1	2	3	4	5
2. The clients (patients) of the hospital where you serve are satisfied with medical services offered.	1	2	3	4	5
3. The quality of services offered by the hospital where you work is excellent.	1	2	3	4	5
4. The services offered to hospital clients where you work are fully satisfying their expectations.	1	2	3	4	5
5. The hospital where I serve makes an annual quality improvement plan for the services offered to the hospital clients.	1	2	3	4	5

Q6. Suggest some ways through which the quality of services offered by the hospital where you serve could be improved.

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Q7. Using your work experience at your hospital of service, identify the most important factors that could be worked on to improve the quality of services offered to clients.

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Thanks for your cooperation and time in responding to questionnaire items.

APPENDIX B

Introductory Letter from the Dean Graduate School

KYAMBOGO UNIVERSITY

P. O. BOX 1 KYAMBOGO Tel: 0414 – 285037, 289267 Fax: 256-41-220464 Website www.kyu.ac.ug

Office of the Dean Graduate School

Your ref.....
Our ref: KYU/GSch/01/13

30th August, 2013

To Whom It May Concern

Dear Sir/Madam

RE: LETTER OF INTRODUCTION

This is to introduce to you **KAGENDA JAVAN** registration numbers **2011/U/HD320/MSc.OPPM** who is a student of Kyambogo University pursuing a Master of Science in Organization and Public Policy Management of Kyambogo University.

He is carrying out a research on ***"Participatory Planning and Service Delivery in Public Hospitals in Uganda"*** A case study of Mulago Hospital in partial fulfillment of the requirements for the award of the Master of Business Administration of Kyambogo University.

This is to kindly request you to grant him permission to carry out this study in your establishment.

Any assistance rendered to him will be highly appreciated.

Yours faithfully,

Dr. M.A. Byaruhanga Kadoodooba
Dean, Graduate School

KYAMBOGO UNIVERSITY
30 AUG 2013
OFFICE OF THE DEAN GRADUATE SCHOOL