

**COMMUNITY PARTICIPATION AND HEALTH SERVICE DELIVERY IN LOCAL
GOVERNMENT; A CASE STUDY OF WAKISO DISTRICT, UGANDA**

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**A RESEARCH DISSERTATION SUBMITTED TO THE COLLEGE OF HUMUNITIES
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UNIVERSITY**

MAY, 2018

DECLARATION

I, Ankunda Charity declare that this research dissertation on “Community participation and health service delivery in local government: A case study of Wakiso District, Uganda” is my original work and to the best of my knowledge, has not been submitted for any award at any academic institution.

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APPROVAL

This research dissertation on “Community participation and health service delivery in local government: A case study of Wakiso District, Uganda” has been done under my guidance and Supervision as an academic Supervisor and is due for submission to Kampala International University in Partial fulfillment of the requirements for the award of a Bachelor’s Degree in Public Administration.

Signature: 

Date: 10th MAY 2018

Supervisor:

DEDICATION

I dedicate this piece of work to the Almighty God who has enabled me to carry out research successfully and my beloved dad Beigure Geoffrey and my beloved mum Jovanis for their endless support both financially and morally without forgetting my dear brothers; Emmanuel, Nelson and my lovely sisters Evas, Diana and Grace. May the Almighty God bless you all.

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LIST OF ACRONYMS

DFID	Department for International Development
MDGs	Millennium Development Goals
MoH	Ministry of Health
OSIEA	Open Society Initiative for East Africa
PHC	Primary Health Care
SDG	Sustainable Development Goal
VPDs	Vaccine-Preventable Diseases
WHO	World Health Organisation

ABSTRACT

The study sought to examine community participation and health service delivery in local government: A case study of Wakiso District, Uganda. The study objectives were; to examine how community involvement in planning affects health service delivery in Wakiso District Local government, Uganda, to examine how community involvement in consultation affects health service delivery in Wakiso District Local government, Uganda and to examine how community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda. The researcher used descriptive and exploratory survey research designs based on results from questionnaires, interviews and observation. Both qualitative and quantitative research designs were used in this study. Qualitative data was obtained through questionnaires, interviews and observation while quantitative data was obtained through computation and analysis. The study population involved 100 participants and these included; Community development officers, District health officers and community members who were available. A sample size of 80 respondents was determined through purposive and random sampling methods. The study used Sloven's formula to determine the sample size of the actual respondents and the sample size is 98 respondents. The researcher used varieties of sampling which included: Purposive and random sampling. Data was collected from primary and secondary sources using questionnaires and interviews. After collecting data, the researcher organized well-answered questionnaire, data was edited and sorted for the next stage. The data was presented in tabular form with frequencies and percentages. The study findings revealed that 70% were males and the 30% remaining were females. This implies that males are the majority. This implies that the most respondents were men due to the societal beliefs that the males are more active and hence capable of ensuring improved health service delivery at the district level. The study concludes that community participation in planning for health programs and services is fundamental to effective and accessible primary health care. There have been ongoing challenges for health professionals engaging with communities in these activities. The study recommends that the health sector should train more people from the rural communities on matters of health and any new health intervention or challenges so that they will continue to be health extension workers in local communities.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter presents the background to the study, statement of the problem, the purpose of the study, objectives of the study, research questions and assumptions, scope of the study, significance of the study, the justification of the study and the operational definitions of terms and concepts as applied to suit the context of the study.

1.1 Background of the Study

Globally, through-out history, improvements in health service delivery were implemented through various forms of community participation: direct service provision by communities, contracting by communities to service providers, new mechanisms for holding public and Non-State Providers accountable for services (Abelson, 2001). The connections between various forms of community participation and effective systems of health service delivery could be assessed in a variety of ways, including improvements in basic human development indicators, such as those set out in international development goals, notably the SDGs.

Recently in Africa, in relation to health service delivery, there are a range of issues related to the role of community participation and stakeholder involvement in service provision. The short route of accountability provides for direct community action, both through community provision of services and through communities holding providers accountable at the point of health service delivery (Abelson, 2008). However, health service delivery failures result when any of these relationships break down. For instance, service failures may occur when citizens are unable to influence public action through the long route of accountability (break on the left side of the triangle), when there is non-payment of salaries to service providers (break on the right side of the triangle) or when there are difficulties in implementing services, such as poorly trained or absent teachers, part of the short route of accountability (break on the bottom of the triangle).

In Uganda, community participation has been for many decades synonymous with in health service delivery. This is because in most citizens in the country has shunned government

programmes such as health campaigns. This also affects on the degree of health service delivery within Uganda as a whole (Jean, 2004). However, health service delivery has continuously failed particularly in Uganda due to poor community participation. For instance, among the health services delivered are garbage collection especially in public health Centre's which is still a problem, the roads they construct wear out quickly, and schools they construct collapse before even a period of ten years (Atkinson and Cope, 1997).

Currently in Uganda, the state of health service delivery has been characterized by several health service delivery initiatives that have had limited success particularly in Wakiso District Local government because of lack of sufficient participation by stakeholders in the development process. The core constraint to fostering community participation especially among the rural people has been over-centralization of decision-making powers and resources thereby creating a communication gap between the beneficiaries such as peasants and the development agencies within Wakiso District Local government. Today, many programs and projects have been introduced and developed with participatory approaches so as to bring the disparate voices of the people into effective health service delivery (Brett 2002).

1.2 Statement of the problem

Many past efforts in development programmes in Wakiso have had limited success because of lack of sufficient participation by stakeholders in the development process (World Bank,2002). The core constraint to fostering popular participation especially among the rural people has been over-centralization of decision-making powers and resources thereby creating a communication gap between the beneficiaries / stakeholders and the development workers in Wakiso district (Eyre & Gauld, 2003).

However, despite the sounding implementation framework, community participation in developmental programs to ensure effective health service delivery has increasingly become a subject of debate and criticisms among different sections of the public in Wakiso District Local government (Barton and Bagenda, 1993). In Wakiso District Local government, the health service delivery is still relatively poor because a limited number of stakeholders including public and private sectors and local and international bodies are involved in the service provision within the local government (Atkinson and Cope, 1997). Because of lack of community participation in

various projects such as health, for this reason the researcher wanted to find out why such important health services are not delivered to the people.

1.3 Purpose of the Study

The purpose of this study was to establish the effect of community participation on health service delivery in local governments particularly Wakiso District Local government, Uganda.

1.4 Objectives of the Study

- i. To examine how community involvement in planning affects health service delivery in Wakiso District Local government, Uganda
- ii. To examine how community involvement in consultation affects health service delivery in Wakiso District Local government, Uganda
- iii. To examine how community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

1.5 Research Questions

- i. How does community involvement in planning affect health service delivery in Wakiso District Local government, Uganda?
- ii. How does community involvement in consultation affect health service delivery in Wakiso District Local government, Uganda?
- iii. How community involvement in monitoring affect health service delivery in Wakiso District Local government, Uganda?

1.6 Scope of the Study

1.6.1 Geographical Scope

The study was carried out in Wakiso District Local government. The District lies in the Central Region of the country, bordering with Nakaseke District and Luweero District to the north, Mukono District to the east, Kalangala District in Lake Victoria to the south, Mpigi District to the southwest and Mityana District to the northwest. Wakiso, where the district headquarters are

located, lies approximately 20 kilometres (12 mi), by road, northwest of Kampala, the capital of Uganda and the largest city in the country. The coordinates of the district are:00 24N, 32 29E.

1.6.3 Content Scope

The study focused on community participation as independent variable while health service delivery as the dependent variable.

1.6.4 Time Scope

The study covered a period (2010-2018). It was carried out in three months and took place from March 2018 up to May 2018 because of the nature of exercise that was undertaken in gathering, editing and processing data.

1.7 Significance of the Study

It is expected that when this study will be carried out and accomplished successfully, it will contribute substantial awareness on benefits of community participation on health service delivery in local government.

The study will contribute to identifying the existing trend of health service delivery in local government in Uganda and thus enable the concerned stakeholders to formulate appropriate policies.

The study also will serve as a future data base for further researches that will be carried out as researchers draw data from the findings which will address the existing gaps in community participation and health service delivery in local government.

1.8 Anticipated limitations

Scarcity of the people to involve in the study, not having access to secondary data sources might be yet another problem, and the most serious problem is time and financial constraints.

Some respondents will be too busy with their daily schedule and will fail to spare time for the questionnaire.

1.9 Operational definitions of key terms

Community participation

The term 'community participation' entails maximization of people's involvement in the spheres or stages of development. (World Bank, 2002)

Local government

Local government refers collectively to administrative authorities over areas that are smaller than a state (Wouter, 2005)

Health service delivery

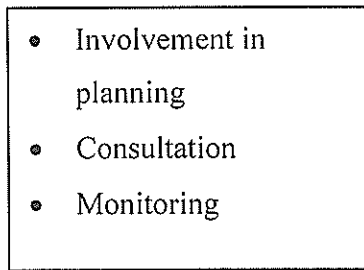
This is the process of getting services as effectively and quickly as possible to the intended recipient.

2.2 Conceptual Framework showing independent and dependent variables

The conceptual framework diagrammatically shows the relationship between the different variables in the study. The independent variable was perceived as the community participation and dependent variable was health service delivery.

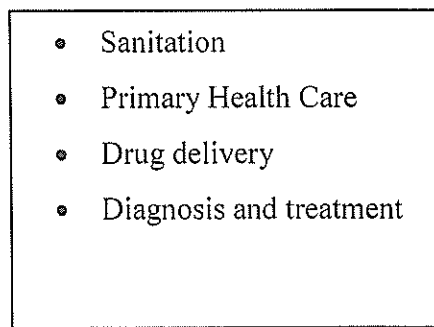
Independent variable

Community Participation

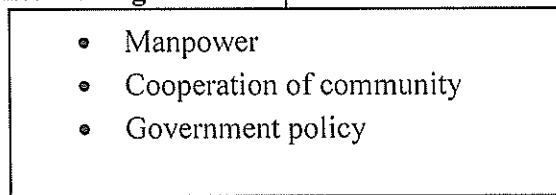


Dependent Variable

Health service delivery



Intervening variable



Source: Frankish, et al., (2002)

It describes a relationship between the two variables the independent variable will be perceived as the community participation and these include; Involvement in planning, Consultation and Monitoring whereas the dependent variable is the health service delivery and these include; Sanitation, Primary Health Care, Drug delivery and Diagnosis and treatment. The intervening variable includes; Manpower, Cooperation of community and Government policy

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The study reviewed literature from various scholars on the major variables of the study included; how community involvement in planning affects health service delivery in Wakiso District Local government, Uganda, how community involvement in consultation affects health service delivery in Wakiso District Local government, Uganda and how community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

2.1 Community planning and health service delivery.

Community participation in planning for health programs and services is fundamental to effective and accessible primary health care. However, according to Frankish, et al., (2002) there have been ongoing challenges for health professionals engaging with communities in these activities. One reason for this is that the term 'community participation' is rarely conceived of, or undertaken as, development of place.

Community Participation in health care is paramount since also it was a key principle in the Alma-Ata Declaration (Abelson & Julia, 2008). The fourth article of the Declaration stated that, 'people have the right and duty to participate individually and collectively in the planning and implementation of their health care'. The seventh article states that 'primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care' (DFID, 2011). Much as community participation in healthcare systems has taken toll in most developed countries in Sub-Saharan Africa there has been much speculation concerning the importance of community participation. Countries have the structures and resources to successfully seek and incorporate the views and opinions of the populace in the design and implementation of health projects and programs (Rifkin, 2001).

Abelson and Julia, (2008) argued Micro planning for immunization service delivery using the Reaching Every District asserts that key leaders such as religious and community leaders should be informed about the danger of not immunizing children against vaccine-preventable diseases

(VPDs). They also should be made aware of the availability of immunization services and the status of coverage. Community leaders should as well be briefed on other indicators in order to gain their cooperation and support (Bennett & Gilson, 2001). Health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information.

It is a good practice that, when health staff give information and feedback to communities about coverage and disease outbreaks, and solicit community input for solving problems, community members themselves can contribute to identifying issues and defining solutions. However, the common problem is lack of community involvement in planning session dates and times and according to Kaufman (1959), the health system can address this through micro planning following consultation at community meetings and during vaccination sessions and activities.

Once immunization-session schedules are determined and agreed to with the communities, it is important that they be adhered to because changing and cancelling scheduled sessions can result in loss of confidence in the service. Unforeseen problems can also sometimes occur, for instance temporary flooding of roads during heavy rains, or transport breakdowns. Whenever possible, to avoid interruption in immunization services (e.g. during the rainy season), health staff should have established communication channels for keeping the community informed of potential changes, and to reschedule sessions when services are interrupted (Martin, 2002).

2.2 Community consultation and health service delivery

Abelson and Julia (2008) argued that limited consultations between the health workers and community on when (time/dates) immunization exercises takes place; and not all the community members are mobilized to come for immunization in time. There is limited participation of the community severely in the immunization activities, in areas such as: registering the patients; making waiting areas more comfortable; transporting vaccines; transporting health workers; and continuing to visit vaccinated children as a way of monitoring the impact of the immunization exercise

Health workers carried out Immunization activities in some Sub Counties and consultation is done between the community and health officials on the immunization venues; and the agreed venues are adhered to. The Community participation is witnessed through mobilizing the

population to go immunization, arranging and cleaning venues, carrying out home visits to remind parents who have not brought their children for Immunization to do so; and crowd control (Bennett & Gilson, 2001).

2.3 How community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

MacQueen et al (1989) further assert that it's important to carry out monitoring and evaluation activities to guarantee the required steps that are being done by responsible people in order to reach the intended result about health in the community. The board should not recommend the actions a community to solve the health issues or who is accountable for what, but what it needs is an organized method to health enhancement that makes use of performance observing tools that will help them reach their goals. Bukenya (2009) stated that the community can help health Centre's in resource management in terms of time, local technology including skills, physical labor, money and material which may be lying idle or under-utilized, because of lack of initiatives to harness these.

The community monitoring program with the intention of facilitating effective participation of communities to monitor aspects of health services by demanding accountability for medicines' availability, deliveries, and for human resources to respect the rights of patients are paramount (Uganda National Health Consumer's Organization, 2011). Involving Ugandans in monitoring health programs within their communities is paying off according to the 2013 review done by the Open Society Initiative for East Africa (OSIEA). Community monitoring will help in influencing the health sector output with the limited resources allocated to them because community involvement brings a feeling of ownership and responsibility (Boot,1991).

The health workers should intensify health education and promotion activities aimed at sensitizing the communities on healthy nutrition (Bennett & Gilson, 2001). They must involve the community in all the levels of planning, implementation, monitoring and evaluation, such as; determining time/dates of the education, educating fellow community members on nutrition, and rendering assistance to nutrition health educators.

Bennett and Gilson (2001) noted that the health workers should involve the community in family health care activities such as; determining dates/time for family health care education exercises,

mobilizing all the community to come for family health care education and promotion, educating fellow community members on family health care, rendering assistance in one way or the other to family health care educators, and reminding their communities of the family health care messages previously taught.

Caroline and Dennis (2005) argues that donors and international NGOs often substitute various short route mechanisms instead of investing in public systems or the sustainability of services in situations of weak governments, or humanitarian crises. Too great an emphasis on ‘community participation’ may idealize the internal coherence and solidarity in communities and miss the essential tasks of supporting effective public institutions.

‘Social capital’ is a useful concept but it is often applied uncritically with inadequate understanding of cultural and political context and vested interests in the status quo. Etzioni (1993) argues that in-service delivery context, while there is no one ‘right path’ to how services should be delivered or ways in which community participation can be strengthened, lessons from experience can guide policymakers and civic organizations:

Hart (1997) stresses that context matters and must be understood - including the relative heterogeneity of the population, the type of service and the spatial context. Moving to scale is likely to require an enabling public sector. Promotion of community participation strengthens the enabling environment and removes disabling factors. Promotion of processes of decentralization takes many forms, and the resulting forms of participation will vary accordingly.

Harvey (1989) maintains that development of participatory processes is never separate from wider social, political contexts - some efforts by donors have foundered due to the attempt to ‘ring fence’ participatory mechanisms for power and politics. Increased transparency of community involvement with public sector agencies is required to improve accountability.

2.4 Related Studies

Victoria and Anirudhha (2006) argue that through participation ordinary people are given opportunity to have a say in how their environment should be planned and developed in future, and that people are able to influence the final outcome of planned action. Most importantly,

public participation contributes to overcoming a sense of hopelessness because it increases the public's senses of efficacy, meaning the belief that the ordinary citizens have the ability and competence to influence municipalities. This means that participation changes dependency into independency.

All these development plans need community participation. Ilan (2002) doubts that these programmes are really addressing the alleviation of poverty. Alleviation of poverty cannot concentrate on one strategy for an example the maize product. This programme is coming from the government not all the communities were consulted. Other communities are talking of healthy food like growing of vegetables. The IDP must include all these types of inputs from the communities.

Blackburn, (2009) argues that the programmes that are imposed by the government tend to be unsustainable because there is no community involvement. He argues further that the government introduced more programmes before it was certain that other programmes were successful or not.

Among the key goals of community participation to be assessed through the case studies in this paper are: improving technical efficiency; improving allocative efficiency; and improving mechanisms of accountability (Bukenya, 2009). Community participation initiatives are related to technical efficiency through such areas as overcoming information asymmetry, providing communities with information on quality through various forms of Monitoring and Evaluation, and ensuring that resources are spent for necessary technical resources by service providers.

Stoker (1997) notes that improving various dimensions of allocative efficiency includes greater attention to the priorities of communities, increased transparency on budgets and public resources through such mechanisms as public budgeting and Public Expenditures Tracking systems, and a subsequent reduction on 'rent seeking' by those in positions of power. Finally, improving accountability involves creating increased transparency from community involvement with public sector agencies, community participation in school management, and community participation in public hearings (Jean 2004).

Community participation is increasingly often endorsed as a means of strengthening state-community synergies. This can be seen in the decentralization cases from Rwanda and Kerala, as well as the local participation law in Bolivia. Emerging demand-driven approaches theoretically ‘empower’ communities to command services and provide a mechanism for (re)building trust and accountability and re-establishing the ‘social contract’ between communities and government (Cernea, 1991). However major challenges surround integrating emerging community participation approaches with traditional sectoral and local government approaches. The objectives of strengthening local governance and delivering better services are often confused. Pressure to meet short term sectoral output targets often distracts attention from institutional reforms necessary to make service delivery systems sustainable in the longer term.

Blackburn, (2009) cites that there are various ways in which community participation processes and mechanisms can strengthen accountability and also affect service delivery outcomes. Citizens can exert their collective voice (which occurs in the relationships between citizens and policy makers) to influence policy, strategies and expenditure priorities at different levels of policy making (national and local) according to their wishes and preferences.

Ilanr (2002) argues that mobilization of community members to identify problems and plan and manage projects helps strengthen local capacity for collective action. There is arguably inherent value in this and additional benefits are often observed beyond the scope of the original project, e.g. formation of self-help groups and micro enterprise development. However, important questions surround the definition of ‘community’ and the ways in which the demands of sub-groups and individuals are represented, e.g. ethnic minorities, women and children. Community-based approaches typically aim to build ‘social capital’ but while this is a useful concept it is often applied uncritically with inadequate understanding of cultural and political context and vested interests in the status quo. Some of the difficulties of exclusion or community power dynamics are illustrated in the West Bengal, Cairo, Bolivia and Uttar Pradesh examples.

Dennis (2005) suggests that there is broad agreement that community-based interventions have the potential to be more responsive to the needs and priorities of beneficiaries (a locative efficiency). There is also some evidence that community-based projects are comparatively cost effective (productive efficiency) because of lower levels of bureaucracy and better knowledge of

local costs. While those projects which draw primarily on locally available skills, materials and financing are clearly likely to be more sustainable, some commentators have argued that this simply amounts to shifting the financial burden of service delivery to potential beneficiaries, which means that care needs to be given to the demands on community time and costs to beneficiaries. Different aspects of allocative efficiency can be seen in the decentralization cases from Kerala and Rwanda, as well as the water programs in Malawi and Ethiopia.

Stewart and Taylor (1995) maintain that strengthening the citizen's voice enhances accountability of policy makers motivating them to be responsive to the needs of communities and stimulates demand for better public services from service providers. Local communities in can be empowered by law to recall their leaders, which motivate elected leaders to be more responsible to the needs of their communities. Citizens can also exercise power as the end users of services, described in the WDR 2004 as "Client Power" over service providers and hold them accountable for access, quantity and quality of services. Improved information about services being provided at the local level, as well as a choice of providers, can represent important elements of client power.

John (2000) specifies the boundaries of service operations management as a field of study, the delivery, and the evaluation of services. Service delivery is an important strategic issue since it allows a government or local government to transpose its strategy onto the operational level and he further notes that the effectiveness of operations strategy is contingent upon making the right design choices.

Skinner (1995) cites that many of the research and theory building is focusing on how to narrow the gap between government and the community in Africa. How can we improve the legitimacy of public administration and regain the trust that community lost in their governments. Community participation, increasing transparency and service delivery improvement seem to be the key issues to deal with this assumed legitimacy problem (Peter and Shaula, 2002)

Essential to the well-being of all people are the effective delivery of basic services such as health, education, water and sanitation (Evans & Appleton, 1993). Accessible, quality services contribute to the achievement of the Millennium Development Goals and to the achievement of

human rights. Yet, widespread evidence shows that services are failing poor people in a large number of countries with negative impacts on human development outcomes. In addressing the failure of services, one key point is that the failure of services is not just technical, it is the result of the lack of accountability of public, private and non-profit organizations to poor people

As set out in the 2004 World Development Report, “Making Services Work for Poor People”, it is possible to assess and approach service delivery through an accountability model for service delivery that includes three groups of stakeholders: citizens, as clients, influence policymakers; policymakers influence service providers; which in turn deliver services to the citizens who are also clients of the services (Chambers, 1994).

Patel (1998) notes that service delivery failures result when any of these relationships break down. For instance, service failures may occur when citizens are unable to influence public action through the long route of accountability (break on the left side of the triangle), when there is non-payment of salaries to service providers (break on the right side of the triangle) or when there are difficulties in implementing services, such as poorly trained or absent teachers, part of the short route of accountability (break on the bottom of the triangle).

McArthur (1996) argues that one way in which improvements in service delivery have been implemented has been through various forms of community participation: direct service provision by communities, contracting by communities to service providers, new mechanisms for holding public and Non-State Providers accountable for services. The connections between various forms of community participation and effective systems of service delivery can be assessed in a variety of ways, including improvements in basic human development indicators, such as those set out in international development goals, notably the Millennium Development Goals (MDGs).

Community participation in service delivery involves far more than the direct delivery of services. A central issue is how different types of participation may contribute to strengthening both the short and long routes of accountability for service delivery (Cheers & Luloff, 2001). Effective forms of community participation in service delivery provide both opportunities and incentives for local government officials to respond to community needs. This can create

opportunities for more downward accountability, and thus reduce the accountability gap between the citizens and policymakers.

McGee (2000) stresses that transparency at the local level may also be enhanced through score cards for public services or supporting local independent media to act as monitors of project activities. These measures serve to promote a process of slow improvements in accountability, both short route and long route, through what the WDR 2004 termed “strategic incrementalism” in a weak institutional environment. This means that service delivery obstacles are reduced with long-term efforts to rebuild state capacity, when feasible, through mechanisms of service delivery. At the same time, effective community participation exists in the context of political, social and legal structures which all shape the feasibility of participatory actions.

Skelcher (1993) notes that community participations are inputs in terms of human, financial, physical and time which are processed through the participation system to produce outputs. Community participation as a concept focuses on the idea that involving stakeholders in decision-making about their communities and broader social issues has important social, economic and political benefits. Their interest in participation emerged from a range of concerns: failures in state-led development.

Manikutty (1998) cites that the risk with an approach to economic development or service delivery that focuses too much on ‘community participation’ is that it may idealize the internal coherence and solidarity in communities, and miss the essential tasks of supporting effective, accountable and transparent public institutions.

Community participation processes include an identification of stakeholders, establishing systems that allow for engagement with stakeholders by public officials, and development of a wide range of participatory mechanisms. Stakeholders are individuals who belong to various identified ‘communities’ and whose lives are affected by specific policies and programs, and/or those who have basic rights as citizens to express their views on public issues and actions.

The proponents of participatory approaches Manikutty, (1997) highlight the value of engagement with stakeholders in terms of greater local ownership of public actions or development projects,

as well as the potential. Clients are usually in a better position to monitor programs and services than most supervisors in public sector agencies who provide the compact and management. When the policymaker- provider link is weak clients may be the best positioned due their regular interaction with frontline providers.

There are also important complementarities or spill-over effects in terms of what are complementarities or spill-over effects from community participation. The engagement of community organizations with public accountability systems can strengthen what Goetz and Jenkins have termed “diagonal accountability” (Goetz and Jenkins, 1999).

In relation to service delivery, there are a range of issues related to the role of community participation and stakeholder involvement in service provision Hillery, (1955). The short route of accountability provides for direct community action, both through community provision of services and through communities holding providers accountable at the point of service delivery. (Manikutty, 1997)

Richard (1986) argues that the long route of accountability emphasizes community voice and mechanisms for ensuring that policy makers respond to community priorities, which links to the nature of political systems. The mechanisms for holding elected and appointed officials accountable are complex and multi-faceted. It is vital to emphasize that elections, even when free and fair, provide only a thin line of accountability. Whether through the short route or the long route, the linkages between community participation and service delivery are complex and highly contextual.

Samanta (2000) cites that the perception of stakeholders and planners is an important consideration in the development and implementation of any public participation program. Public participation is often a requirement for planners; however, it is always optional for community. Community chooses to participate because they expect a satisfying experience and hope to influence the planning process.

Samanta (2000) furthermore indicates that participation can offer a variety of rewards to community. These can be intrinsic to the involvement (through the very act of participation) or

instrumental (resulting from the opportunity to contribute to public policy). The planner's expectations are also important in that an effective public participation program can lead to a better planning process and product as well as personal satisfaction.

Manzoor (1980) *Journal on Community Participation* asserts that true or active participation means that the people should be knowledgeable about their own health problems. Communities should identify the needs for their solution or reduction, draw out plans of actions according to the priority and the resources available organize and implement the programmes, and monitor and control their progress; periodically evaluate for getting the feedback, and do the reprogramming. However, under poor social and economic conditions, it may be hard to expect spontaneous participation from the people (Epstein, 2009). People have to be mobilized and encouraged to take greater interest and responsibilities for the maintenance of their own health. Initially, the involvement may be passive, and this has to be gradually and progressively made more active participation.

Community participation in healthcare systems has recently become a growing theme in healthcare reforms. Deschesnes et al, (2003) further stresses that community health sector coalition, in the name of successful cooperation has proven effective in creating a shared vision, a positive working climate, effective leadership in participatory decision-making. Community participation is vital in formalized procedures, negotiation mechanisms and shared agreements among interested partners. However, according to Abelson (2008), there are fears on whether countries have the structures and resources to successfully seek and include the views and beliefs of the public in the design and implementation of health projects and programs.

Roy, Somnath and Sharma (1986) stresses that community involvement includes first, the services may be organized on a community basis with wide and easy access of the people to the services provided or the community may contribute to the operation and maintenance of services. The community may participate in planning and managing the services, they may make inputs into overall policies, strategies, and work plan of the programme or may help in overcoming the section and interest conflicts in the community and the group is capable of engaging in supportive efforts for the benefit of all.

According to WHO (2012) community mobilization can infuse new energy into an issue through community buy-in and support. Community participation can also expand the base of community support for an issue or organization. It can help a community overcome denial of a health issue; and increase access to funding opportunities for organizations and promote long-term, organizational commitment to social and health-related issues.

The World Health Organization defined Health Education as comprising of consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health (WHO, 1998).

Health education is one important activity that is commonly undertaken to promote health and Rifkin (1996); it is the communication of information that enables people to make informed decisions about health-related activities at all stages of the health cycle.

Local people have a great amount of experience and insight into what works for them, what does not work for them, and why. They therefore contribute to the success of any Health Education intervention (Mukoma and Flisher, 2004). Involving local people in health education can increase their commitment to the community health education programs. Health education can help communities to develop appropriate skills and knowledge to identify and solve their problems on their own. Involving local people helps to increase the resources available for the programme, promotes self-help and self-reliance, and improves trust and partnership between the community and health workers. It is also a way to bring about social learning or both health workers and local people.

Social learning is learning that takes place at a wider scale than individual or group learning, up to a societal scale, through social interaction between peers. It may or may not lead to a change in attitudes and behavior. More specifically, to be considered social learning, a process must: demonstrate that a change in understanding has taken place in the individuals involved; demonstrate that this change goes beyond the individual and becomes situated within wider social units or communities of practice; and occur through social interactions and processes between actors within a social network (Reed et al., 2010). Therefore, if you involve the local

community in a programme which is developed for them, you will find they will gain from these benefits.

Health education to the community should be a prime function of the health workers and village level representatives. Dubey, Bardhan, & Sharma (1985) assert that in this endeavor, functionaries of other sectors such as social and women's welfare, education, agriculture and animal husbandry and voluntary agencies like youth clubs can contribute very significantly. Health education in schools and adult education sessions should incorporate various health problems and the members of the community, both individually and collectively can play a very important role in the promotion of these activities.

Community participation could be helpful in disaster situations. In disasters, community participation in education is the active involvement of people from communities preparing for, or directing to, disasters (Epstein, 2009). True participation means the involvement of the people concerned in analysis, decision-making, planning and programme implementation, as well as in all the activities.

Community should participate in the search and rescue to reconstruction activities that people affected by disasters undertake spontaneously without the involvement of external agencies. While the opportunities for community participation may vary greatly from place to place and at different points in the disaster-management cycle, a participatory approach to disaster-related activities should be promoted to achieve sustainable development (World Resources Institute, 1990). Health education might involve subjects such as the risk of flooding in areas where people are building houses, the location of earthquake shelters or the areas where safe defecation is possible in a new emergency settlement. Community participation may as well be used to improve nutrition status of people. The poor nutritional status of the people particularly of the pregnant and nursing mothers, and the infants and children can be substantially improved by organizing and conducting nutrition education programmes in the community and in the schools.

Health education encourages people to make kitchen gardens and community gardens, and by educating the people on food hygiene. Steps also need to be taken to encourage growing locally more foods such as cereals, pulses, vegetables, fruits, milk, fish and poultry products through

cooperative and other efforts so as to make these easily accessible and affordable. Simultaneously, the purchasing capacity of the families might be improved through a variety of income generating schemes. In addition, for the moderately and severely malnourished groups, special nutrition programmes are to be organized. In these endeavors, functionaries from other sectors such as agriculture, animal husbandry, irrigation, banks and cooperatives, social and women's welfare, voluntary organizations and other community groups can play a very significant role (Roy & Sharma, 1986).

Roy (1986) argues in his Journal about Primary health care in India that Health education together with community participation improves the community health at all levels, including leaders, women and school children should be educated on continuous basis about the importance of proper maintenance of water and the use of safe water and observation of personal hygienic practices should also be emphasized in rural communities.

Organized method sought to be made to review and classify resources of safe water and to undertake analysis of water. Regular measures should be made for refinement of water through chlorination etc., before using for drinking and other household roles (MoH, 2012). It's vital for rural community in this case to be systematic about resources for building household and community latrines, and making provisions for collection and disposal of human and animal wastes be part of the community involvement to their health but this can only be done through efficient health education involving the locals (Eyre and Gauld 2003). Proper educational programmes on all these aspects for the children, youths and adults and the mothers should be organized in a systematic manner.

Active community participation in organizing all the above activities and programmes would be the key to success, this is because poor sanitation is one of the highly reported health problem that needs to be addressed in rural areas in (Uganda Dodge, 2011). This is witnessed through limited and poor water sources and latrines (Uganda Demographic and Health Survey 2011).

According to WHO (2012), sanitation education is necessary as it is concerned specifically with communicating on those areas of health that are related to water supply, sanitation, vector-borne

disease control, and hygiene practice. Following a disaster, hygiene education is particularly important for reducing the risk of communicable disease and its transmission.

Involving the community in health education programs is generally understood to be a beneficial action, although some analysts express concern over the fact that researchers have not clearly separated the effects of the various components of community interventions (McBride 2004). Flay's (2000) research actually states that the "effects of community programs may tend to be larger, occur in more domains, and are more likely to be maintained than allowing only health workers. White and Pitts (1997) and Donaldson et al. (1996) asserted that smoking-related programs are effective in the longer-term only if linked to community-wide activities. Orpinas et al. (2000) also calls for the involvement of parents and the community in school health education; and Mukoma and Flisher (2004), too, speak of the significance of parental commitments.

Immunization, or immunisation, is the process by which an individual's immune system becomes fortified against an agent (known as the immunogen) (Ginsberg, 2002). Vaccines fuel the body's own resistant system to protect the person against consequent infection or disease. When this system is exposed to molecules that are foreign to the body, called non-self, it will orchestrate an immune response, and it will also develop the ability to quickly respond to a subsequent encounter because of immunological memory. This is a function of the adaptive immune system. Therefore, by exposing an animal to an immunogenic in a controlled way, its body can learn to protect itself: this is called active immunization.

Life-saving vaccines are becoming accessible, yet the institution of a new vaccine does not necessarily require a separate strategy and training (WHO, 2012). The training of both health workers and community member on the use of these vaccines eliminates high ignorance rates that have forced some parents to deny their children the right to vaccination as a way of purportedly preventing them from being given a poisonous substance (MoH, 2012).

Mukoma and Flisher (2004) noted that micro planning for immunization service delivery using the Reaching Every District asserts that key leaders such as religious and community leaders should be informed about the danger of not immunizing children against vaccine-preventable

diseases (VPDs). They also should be made aware of the availability of immunization services and the status of coverage. Community leaders should as well be briefed on other indicators in order to gain their cooperation and support. Health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information.

In forecasting for Immunization, health staff should turn to communities about service locations and timing to ensure an appropriate service and the following options can be agreed upon: having immunization services at the convenience of the working parents in order for them to be able to bring their children for immunization; moving vaccination hours from early mornings to afternoons in areas where mothers are busy in the fields or selling at the market in the morning; and so on (Mukoma and Flisher, 2004). It is a good practice that, when health staff give information and feedback to communities about coverage and disease outbreaks, and solicit community input for solving problems, community members themselves can contribute to identifying issues and defining solutions. However, the common problem is lack of community involvement in planning session dates and times and according to Kaufman (1959), the health system can address this through micro planning following consultation at community meetings and during vaccination sessions and activities.

Once immunization-session schedules are determined and agreed to with the communities, it is important that they be adhered to because changing and cancelling scheduled sessions can result in loss of confidence in the service (Deininger & Mpuga, 2004). Unforeseen problems can also sometimes occur, for instance temporary flooding of roads during heavy rains, or transport breakdowns. Whenever possible, to avoid interruption in immunization services (e.g. during the rainy season), health staff should have established communication channels for keeping the community informed of potential changes, and to reschedule sessions when services are interrupted (Martin, 2002).

Community organization involves all sectors of the population in a community-wide effort to address a health, social, or environmental matter (Mukoma and Flisher, 2004). It brings together policy makers and opinion leaders, local and central governments, professional groups, religious groups, businesses, and individual community members. It empowers individuals and groups to

take some kind of action to facilitate change, and part of the process includes mobilizing necessary resources, disseminating information, generating support, and fostering cooperation across public and private sectors in the community (Butterfoss et al., 1993).

Wilkinson (1998) stated that, during the implementation stage of the Immunization exercise, communities can assist with arranging a clean outreach site (school; community meeting room, etc.). Well-versed members about the immunization activity can also communicate to other members when the health worker arrives at the outreach site and may also take part in registering patients, crowd control, and making waiting areas more comfortable (by providing shade and organizing space and seating). Health education-broadcasting appropriate messages, motivating fellow community members to use the immunization and primary health care (PHC) services, transporting vaccines and health workers are other activities where community members may help (Creese, 1997). Some chosen community members may help in arranging home visits when children are behind schedule, to explain immunization and to motivate care givers.

Taylor (2004) asserts that the community has a reason to bear the mandate of monitoring and evaluating the Immunization process and outcomes. Community leaders and health workers can contribute by responding to questions about the quality of services. Many factors influence health and well-being in a community, and many entities and individuals in the community have a role to play in responding to community health needs (Butler & Khavarpour, 1999).

There is a need to have a community health-committee that perceives a prerequisite for a background within which a community can take a complete approach to upholding and enhancing health (Mukoma and Flisher, 2004). The health committee examines the health desires of the community, regulates its resources and its possessions for stimulating health; advance and establish a plan for activities and determine where the concerns should be for the exact results.

MacQueen et al (1989) further assert that it's important to carry out monitoring and evaluation activities to guarantee the required steps that are being done by responsible people in order to reach the intended result about health in the community. The board should not recommend the actions a community to solve the health issues or who is accountable for what, but what it needs is an organized method to health enhancement that makes use of performance observing tools

that will help them reach their goals. Bukenya (2009) stated that the community can help health centres in resource management in terms of time, local technology including skills, physical labor, money and material which may be lying idle or under-utilized, because of lack of initiatives to harness these.

Substantial financial and human resources can be mobilized from the community (Stokols et al., 2003). Communities with institutional structures such as a local body or council, a cooperative etc., can mobilize resources for the community purpose more easily than those relying on individual and voluntary contributions (Agrawal & Gibson, 1999). In some voluntary projects small regular contributions by rural families have served as a kind of Group Insurance Schemes and have covered up to 50 percent of the total cost of primary health care in the community (Starfield, Shi, & Macinko, 2005). Such an approach may bring out a fundamental improvement in the quality and coverage of health care of rural people.

As the allocation of a large proportion of health spending; and given their size and complexity, health centers provide many opportunities for corruption, as (Vian, 2013) describes. Money leaks from health centers through opaque procurement of equipment and supplies, ghost employees, exaggerated construction costs and inflated health centers' price tags. In developing countries, the result is a depleted budget for other necessary health care services such as primary health care programmes. Balabanova and McKee, (2002) stress that it is patients that suffer, either because they are asked to pay bribes for treatment that should be free, or because treatment decisions are based on financial motivation rather than medical need and the effects are felt clearly in rural areas.

2.5 Research Gaps

Most scholars including Brett (2003); Midley (1986) noted that the main arguments used against the regular use of referendums are that ordinary people do not have the ability to make complex decisions, minorities can have their basic rights abused, and that the use of referendums undermines representative democracy. The reality is that larger groups are better at making good decisions, and we cover this in other parts of the website. Research shows that people living in countries where referendums are used regularly are better informed. The study therefore

advocates for the protection of minorities since it is important and their rights must be protected but we already have extensive human rights and equality legislation in place (Christensen, 2010). Our research shows that in the past one or two referendums could be considered to have had a negative impact on equality issues. In practice, the use of referendums has evolved in line with the general progress towards greater equality in western societies. In addition, the theory fails to disclose that it is sometimes not realistic especially in African context due to bureaucratic and corruption tendencies. Thus, the study intends to advocate for effective government policies in order to improve on service delivery through community participation.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter dealt with practical procedures that were used for carrying out the study and how data was collected and analyzed. It portrays an explicit description of the research design, the survey procedure, sampling design, sampling procedure, sample size, data collection methods and instruments that were used by the researcher.

3.1 Research design

The researcher used descriptive and exploratory survey research designs based on results from questionnaires, interviews and observation. Both qualitative and quantitative research designs were used in this study. Qualitative data was obtained through questionnaires, interviews and observation while quantitative data was obtained through computation and analysis

3.2 Population of the study

The study population involved 100 participants and these included; Community development officers, District health officers and community members who were available.

3.3 Sample size

A sample size of 80 respondents was determined through purposive and random sampling methods. This is so because the nature of data to be generated requires different techniques for better understanding of the research problem under investigation. Besides this approach is also commonly known for achieving higher degree of validity and reliability as well as elimination of biases as per Amin (2005).

The Sloven's formula (1978) was used to determine the minimum sample size.

$$n = \frac{N}{1 + Ne^2}$$

Where n is the sample size

N is the sample population

e² is the level of significance (0.05)

Therefore, $n = \frac{100}{1 + 100(0.05^2)}$

$$n = 80 \text{ employees}$$

Therefore the sample size was 80

Table 1: The sample size of the respondents

Respondents	Population	Sample size
District health officers	5	4
Community development officers	4	3
Community members	91	73
Total	100	80

Source: Primary data (2018)

3.4 Sampling Techniques

The study used varieties of sampling which included: Purposive sampling, and simple random sampling.

3.4.1 Purposive sampling

Purposive sampling involved selecting a number of District Health officers, city mayor and Community development officers based on the community participation in relation to service delivery. These were purposely selected because they headed different sections of people within the community and thus had sufficient knowledge about the community participation and health service delivery. This method was appropriate because the sample selected comprised of informed persons who can provide data that would be comprehensive enough to gain better insight into the problem.

3.4.2 Simple Random sampling

Random sampling was used in selecting respondents from the population listing by chance. Local peasants were randomly selected so as to get equal representation of the respondents. In that way, every member had an equal chance to be selected.

3.5 Sources of data

The researcher used both primary and secondary data. Primary data was collected through direct interactions with the respondents in one form or through personal interviews as well as observation. Secondary data was obtained from various publications of the central and Local Governments, technical and trade journals, books, magazines and newspapers, published records and statistics, historical documents and other sources of published information.

3.6 Data collection methods

The researcher collected the primary data by use of questionnaires, interviews.

3.6.1 Questionnaire

A questionnaire is a form containing a series of questions and providing spaces as well as options to be attempted by the respondents themselves. The questionnaires were composed of close-ended questions, open-ended questions, and leading questions pertaining the research variables and objectives.

3.6.2. Structured Interview

This is where the researcher asks a standard set of questions and nothing more. The researcher carried out a face-to-face interaction with the respondents in order to obtain information that was relevant and adequate to this research. The face-to-face interview enabled the researcher to establish rapport with potential respondents and thereafter gain the more needed cooperation and thus more data. The interviews were carried out in English language since all the participants were more conversant with it.

3.7. Data analysis

The raw data that was collected from the field, examined, and analyzed by editing, coding and employing descriptive statistics in order to give more meaning to the data. The data was then edited in order to screen the relevant data from the raw data that would carry meaning to the study. During this process, the researcher translated the data into numerical figures to add meaning and easy understanding of the data. The results then were presented in form of percentages, frequency tables and graphs for easy comprehension and later deductions were made from the analyses.

3.8 Ethical Considerations

The researcher carried out the study with full knowledge and authorisation of the administration of Wakiso District. The researcher first of all would acquire an introductory letter from the University which she would use to eliminate suspicion. The researcher thereafter went ahead to select respondents, and arrange for dates upon which she would deliver questionnaires as well as pick them in addition to making appointments for interviews to be conducted. The researcher was charged with a task of ensuring that she would assure the respondents of their confidentiality as this was paramount to research.

3.9 Anticipated limitations to the study

The researcher encountered problems of financial difficulties, especially in areas of printing, transportation, internet costs and feeding among others, this constraint were averted by seeking financial sponsorship from friends and well wishers

Some respondents were too busy with their daily schedule and failed to spare time for the questionnaire. In such circumstances the researcher would give ample time to those respondents.

CHAPTER FOUR

PRESENTATIONS, INTERPRETATIONS AND ANALYSIS OF DATA

4.0 Introduction

This chapter covers the presentation of the findings according to the themes of the study which were: to examine how community involvement in planning affects health service delivery in Wakiso District Local government, Uganda, to examine how community involvement in consultation affects health service delivery in Wakiso District Local government, Uganda and to examine how community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

4.1 Demographic characteristics of respondents

Under this section, the researcher was interested in finding out the demographic characteristics of the respondents. They are presented as follows:

4.1.1 Gender of Respondents

The researcher wanted to know the gender or sex distribution of the respondents and this is shown in the following table and illustration. This section indicates the both sexes with the community.

Table 1 : Gender distribution of the respondents

Gender	Frequency	Percentage (%)
Males	56	70
Females	24	30
Total	80	100

Source: Primary Data (2018)

In the above table 1, the study findings revealed that the sample constituted of 80 respondents of which 70% were males and the 30% remaining were females. This implies that males are the majority. This implies that the most respondents were men due to the societal beliefs that the

males are more active and hence capable of ensuring improved health service delivery at the district level.

4.1.2 Age of the respondents

The study went on to establish the different age groups of the respondents and the findings were as presented in table 2. The study also involved all respondents who are responsible and with mature understanding.

Table 2 : Age distribution of the respondents

Age	Frequency	Percentage (%)
20-25 years	28	35
26-35 years	30	38
36-45 years	12	15
46-55 years	8	10
56 years +	2	3
Total	80	100

Source: Primary Data (2018)

The study revealed that the majority of the respondents fell in the age category 26-35 years with a 38% representation. Age category 20-25 had a total response of 35%, while 46- 55 years had 10% and the remaining 3% of the respondents were above 56 years. This implies that majority of the respondents were middle aged adults who often do understand the role of community participation towards health service delivery.

4.1.3 Marital Status of the Respondents

The study further went on to establish the marital status of the respondent and the findings were as represented in table 3. The researcher was also interested in finding out the marital status of respondents.

Table 3: Marital status of the respondents

Marital Status	Frequency	Percentage
Single	18	22.5
Married	30	37.5
Divorced	23	28.75
Widowed	9	11.25
Total	80	100

Source: Primary Data (2018)

The study established that the majority of the respondents were married at 37.5%. The divorced comprised of 28.75%, the widowed were 11.25% whereas the single were only 22.5%. Study findings established that, the majority were married and that due to their statuses, had children to take care of and yet resources were not readily available. This implies that this group of people is forced to participate in the community activities of health service delivery.

4.1.4 Education Levels of the Respondents

The study also sought about the educational levels of the respondents and the findings were as represented in table 4. Under this section, the researcher was interested in finding out the education status of all respondents involved in the study.

Table 4: Educational Level of the respondents

Education level	Frequency	Percentage
Primary level	15	18.75
Secondary	21	26.25
Certificate level	18	22.5
Diploma	10	12.5
Degree	7	8.75
Master's degree	9	11.25
Total	80	100

Source: Primary Data (2018)

Study findings in table 4 revealed that the least represented level of education was the degree level which comprised of 8.75%, followed by 11.25% of master’s degree, 12.5% of the respondents of diploma, 22.5% of the respondents were certificate holders, 26.25% were in the secondary school level and the remaining 18.75% were in primary school level. This implies that semi-illiterate, thus with low levels of education hence did not fully understand the concepts of community participation and health service delivery.

4.2 Findings on Community planning and health service delivery

To achieve this objective, the respondents were asked about the Community planning and health service delivery. These are presented as follows:

Table 5: Community participation in planning for health programs and services is fundamental to effective and accessible primary health care

Response	Frequency	Percent
Strongly Disagree	2	2.5
Disagree	7	8.8
Not sure	9	11.3
Agree	22	27.5
Strongly Agree	40	50.0
Total	80	100.0

Source: Primary Data (2018)

The table above indicates that 2.5% of the respondents strongly disagreed, 8.8% of the respondents disagreed, 11.3% of the respondents were not sure, 27.5% agreed and the remaining 50% of the respondents strongly agreed that community participation in planning for health programs and services is fundamental to effective and accessible primary health care and this implies that majority of the respondents were aware that planning for health programs is vital.

Table 6: Community leaders should as well be briefed on other indicators in order to gain their cooperation and support

Response	Frequency	Percent
Strongly Disagree	2	2.5
Disagree	6	7.5
Not sure	11	13.75
Agree	21	26.25
Strongly Agree	40	50
Total	80	100

Source: Primary Data (2018)

The study results revealed that 2.5% of the respondents strongly disagreed, 7.5% of the respondents disagreed, 13.75% of the respondents were not sure, 26.25% of the respondents agreed and the remaining 50% strongly agreed that community leaders should as well be briefed on other indicators in order to gain their cooperation and support. This implies that there is need for community briefing regarding health service delivery.

Table 7: Health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information

Response	Frequency	Percent
Strongly Disagree	4	5
Disagree	9	11.25
Not sure	10	12.5
Agree	30	37.5
Strongly Agree	27	33.75
Total	80	100

Source: Primary Data (2018)

The table above indicates that 5% of the respondents strongly disagreed, 11.25% of the respondents disagreed, 12.5% of the respondents were not sure, 37.5% of the respondents agreed

and the remaining 33.75% of the respondents strongly agreed that health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information. This implies that it is vital ensure better communication skills to improve on the health service delivery.

Table 8: The common problem is lack of community involvement in planning session dates and times

Response	Frequency	Percent
Strongly Disagree	4	5
Disagree	2	2.5
Not sure	10	12.5
Agree	40	50
Strongly Agree	24	30
Total	80	100

Source: Primary Data (2018)

The study results presented in the table above indicate that 5% of the respondents strongly disagreed, 2.5% of the respondents disagreed, 12.5% of the respondents were not sure, 50% of the respondents agreed and the remaining 30% strongly agreed. This implies that the majority of the respondents revealed that the common problem is lack of community involvement in planning session dates and times. This implies that it is vital to involve community members in planning for health programmes within the community.

4.3 Findings on Community consultation and health service delivery

To achieve this objective, the respondents were asked about the Community consultation and health service delivery. These are presented as follows:

Table 9: There are limited consultations between the health workers and community when certain health services are offered

Response	Frequency	Percent
Strongly Disagree	4	5
Disagree	8	10
Not sure	7	8.75
Agree	40	50
Strongly Agree	21	26.25
Total	80	100

Source: Primary Data (2018)

It was revealed that 5% of the respondents strongly disagreed, 10% of the respondents disagreed, 8.75% of the respondents were not sure, 50% of the respondents agreed and the remaining 26.25% of the respondents strongly agreed. This implies that majority of the respondents revealed that There are limited consultations between the health workers and community when certain health services are offered. This implies that there is need to ensure several consultations regarding health service delivery.

Table 10: Not all the community members are mobilized to come for health services in time

Response	Frequency	Percent
Strongly Disagree	9	11.25
Disagree	4	5
Not sure	10	12.5
Agree	27	33.75
Strongly Agree	30	37.5
Total	80	100

Source: Primary Data (2018)

According to the table above, 11.25% of the respondents, 5% of the respondents disagreed, 12.5% of the respondents were not sure, 33.75% of the respondents agreed and 37.5% strongly

agreed. This implies that majority of the respondents revealed that not all the community members are mobilized to come for health services in time. This implies that there is need for sensitize all the community members regarding health service delivery.

Table 11: Some health workers tend to be rude when community members try to consult from them

Response	Frequency	Percent
Strongly Disagree	3	3.75
Disagree	6	7.5
Not sure	10	12.5
Agree	28	35
Strongly Agree	33	41.25
Total	80	100

Source: Primary Data (2018)

The table above illustrates that 3.75% of respondents strongly disagreed, 7.5% disagreed, 12.5% of the respondents were not sure, 35% of the respondents agreed and the remaining 41.25% of the respondents strongly agreed that some health workers tend to be rude when community members try to consult from them. This implies that health workers sometimes are rude when delivering services and therefore there is need to address this issue.

Table 12: Most community members sometimes ignore consultation about their health problems they face

Response	Frequency	Percent
Strongly Disagree	5	6.25
Disagree	10	12.5
Not sure	9	11.25
Agree	23	28.75
Strongly Agree	33	41.25
Total	80	100

Source: Primary Data (2018)

The results presented in the table above indicate that 6.25% of the respondents strongly disagreed, 12.5% of the respondents disagreed, 11.25% were not sure, 28.75% of the respondents agreed and the remaining 41.25% of the respondents strongly agreed that most community members sometimes ignore consultation about their health problems they face.

4.4 Findings on how community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

To achieve this objective, the respondents were asked about the How community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda. These are presented as follows:

Table 13: Community monitoring programs help to monitor aspects of health services by demanding accountability for medicines' availability

Response	Frequency	Percent
Strongly Disagree	4	5
Disagree	4	5
Not sure	8	10
Agree	30	37.5
Strongly Agree	34	42.5
Total	80	100

Source: Primary Data (2018)

The study results presented in the table above indicate that 5% of the respondents strongly disagreed, 5% of the respondents disagreed, 10% of the respondents were not sure, 37.5% of the respondents agreed and the remaining 42.5% of the respondents strongly agreed. This implies that majority of the respondents agreed that community monitoring programs help to monitor aspects of health services by demanding accountability for medicines' availability.

Table 14: Involving community members in monitoring health programs within their communities help in influencing the health sector output with the limited resources

Response	Frequency	Percent
Strongly Disagree	1	1.25
Disagree	4	5
Not sure	8	10
Agree	27	33.75
Strongly Agree	40	50
Total	80	100

Source: Primary Data (2018)

According to the results presented in the table above, 1.25% of the respondents strongly disagreed, 5% of the respondents disagreed, 10% of the respondents, 33.75% agreed and the

remaining 50% strongly agreed that Involving community members in monitoring health programs within their communities help in influencing the health sector output with the limited resources. This implies that there is always need to involve community members in health programmes so as to improve on health service delivery

Table 15: There is need to involve community members in all levels of monitoring and evaluation, such as; determining time/dates of the education and educating fellow community members on nutrition

Response	Frequency	Percent
Strongly Disagree	4	5
Disagree	4	5
Not sure	8	10
Agree	30	37.5
Strongly Agree	34	42.5
Total	80	100

Source: Primary Data (2018)

The study results presented in the table above indicate that 5% of the respondents strongly disagreed, 5% of the respondents disagreed, 10% of the respondents were not sure, 37.5% of the respondents agreed and the remaining 42.5% of the respondents strongly agreed. This implies that majority of the respondents agreed that there is need to involve community members in all levels of monitoring and evaluation, such as; determining time/dates of the education and educating fellow community members on nutrition.

Table 16: It is important to monitor health activities in order to reach the intended result about health in the community

Response	Frequency	Percent
Strongly Disagree	2	2.5
Disagree	5	6.25
Not sure	9	11.25
Agree	21	26.25
Strongly Agree	43	53.75
Total	80	100

Source: Primary Data (2018)

The results presented in the table above indicate that 2.5% of the respondents strongly disagreed, 6.25% of the respondents disagreed, 11.25% were not sure, 26.25% of the respondents agreed and the remaining 53.75% of the respondents strongly agreed that It is important to monitor health activities in order to reach the intended result about health in the community. This indicates there is still a lot that needs to be done to monitor the health programmes within the community

CHAPTER FIVE

DISCUSSIONS OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses, concludes and recommends reflecting on the study findings presented in the previous chapter.

5.1 Discussion of findings

5.1.1 Demographic characteristics of respondents

The study findings revealed that 70% were males and the 30% remaining were females. This implies that males are the majority. This implies that the most respondents were men due to the societal beliefs that the males are more active and hence capable of ensuring improved health service delivery at the district level.

The study revealed that the majority of the respondents fell in the age category 26-35 years with a 38% representation. Age category 20-25 had a total response of 35%, while 46- 55 years had 10% and the remaining 3% of the respondents were above 56 years. This implies that majority of the respondents were middle aged adults who often do understand the role of community participation towards health service delivery.

The study established that the majority of the respondents were married at 37.5%. The divorced comprised of 28.75%, the widowed were 11.25% whereas the single were only 22.5%. Study findings established that, the majority were married and that due to their statuses, had children to take care of and yet resources were not readily available. This implies that this group of people is forced to participate in the community activities of health service delivery.

Study findings revealed that the least represented level of education was the degree level which comprised of 8.75%, followed by 11.25% of master's degree, 12.5% of the respondents of diploma, 22.5% of the respondents were certificate holders, 26.25% were in the secondary school level and the remaining 18.75% were in primary school level. This implies that semi-

illiterate, thus with low levels of education hence did not fully understand the concepts of community participation and health service delivery.

5.1.2 Community planning and health service delivery

It was found out that 2.5% of the respondents strongly disagreed, 8.8% of the respondents disagreed, 11.3% of the respondents were not sure, 27.5% agreed and the remaining 50% of the respondents strongly agreed that community participation in planning for health programs and services is fundamental to effective and accessible primary health care and this implies that majority of the respondents were aware that planning for health programs is vital.

The study results revealed that 2.5% of the respondents strongly disagreed, 7.5% of the respondents disagreed, 13.75% of the respondents were not sure, 26.25% of the respondents agreed and the remaining 50% strongly agreed that community leaders should as well be briefed on other indicators in order to gain their cooperation and support. This implies that there is need for community briefing regarding health service delivery.

It was found out that 5% of the respondents strongly disagreed, 11.25% of the respondents disagreed, 12.5% of the respondents were not sure, 37.5% of the respondents agreed and the remaining 33.75% of the respondents strongly agreed that health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information. This implies that it is vital ensure better communication skills to improve on the health service delivery.

The study also found out that 5% of the respondents strongly disagreed, 2.5% of the respondents disagreed, 12.5% of the respondents were not sure, 50% of the respondents agreed and the remaining 30% strongly agreed. This implies that the majority of the respondents revealed that the common problem is lack of community involvement in planning session dates and times. This implies that it is vital to involve community members in planning for health programmes within the community.

5.1.3 Community consultation and health service delivery

It was revealed that 5% of the respondents strongly disagreed, 10% of the respondents disagreed, 8.75% of the respondents were not sure, 50% of the respondents agreed and the remaining

26.25% of the respondents strongly agreed. This implies that majority of the respondents revealed that There are limited consultations between the health workers and community when certain health services are offered. This implies that there is need to ensure several consultations regarding health service delivery.

The study results found out that 11.25% of the respondents, 5% of the respondents disagreed, 12.5% of the respondents were not sure, 33.75% of the respondents agreed and 37.5% strongly agreed. This implies that majority of the respondents revealed that not all the community members are mobilized to come for health services in time. This implies that there is need for sensitize all the community members regarding health service delivery.

It was found out that 3.75% of respondents strongly disagreed, 7.5% disagreed, 12.5% of the respondents were not sure, 35% of the respondents agreed and the remaining 41.25% of the respondents strongly agreed that some health workers tend to be rude when community members try to consult from them. This implies that health workers sometimes are rude when delivering services and therefore there is need to address this issue.

It was also discovered that 6.25% of the respondents strongly disagreed, 12.5% of the respondents disagreed, 11.25% were not sure, 28.75% of the respondents agreed and the remaining 41.25% of the respondents strongly agreed that most community members sometimes ignore consultation about their health problems they face.

5.1.4 How community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

It was found out that 5% of the respondents strongly disagreed, 5% of the respondents disagreed, 10% of the respondents were not sure, 37.5% of the respondents agreed and the remaining 42.5% of the respondents strongly agreed. This implies that majority of the respondents agreed that community monitoring programs help to monitor aspects of health services by demanding accountability for medicines' availability.

The study findings revealed that 1.25% of the respondents strongly disagreed, 5% of the respondents disagreed, 10% of the respondents, 33.75% agreed and the remaining 50% strongly agreed that Involving community members in monitoring health programs within their

communities help in influencing the health sector output with the limited resources. This implies that there is always need to involve community members in health programmes so as to improve on health service delivery

The study results revealed that 5% of the respondents strongly disagreed, 5% of the respondents disagreed, 10% of the respondents were not sure, 37.5% of the respondents agreed and the remaining 42.5% of the respondents strongly agreed. This implies that majority of the respondents agreed that there is need to involve community members in all levels of monitoring and evaluation, such as; determining time/dates of the education and educating fellow community members on nutrition.

It was also discovered that 2.5% of the respondents strongly disagreed, 6.25% of the respondents disagreed, 11.25% were not sure, 26.25% of the respondents agreed and the remaining 53.75% of the respondents strongly agreed that It is important to monitor health activities in order to reach the intended result about health in the community. This indicates there is still a lot that needs to be done to monitor the health programmes within the community

5.2 Conclusion

5.2.1 Community planning and health service delivery.

The study concludes that community participation in planning for health programs and services is fundamental to effective and accessible primary health care. There have been ongoing challenges for health professionals engaging with communities in these activities.

It also concludes that micro planning for immunization service delivery using the Reaching Every District asserts that key leaders such as religious and community leaders should be informed about the danger of not immunizing children against vaccine-preventable diseases (VPDs). They also should be made aware of the availability of immunization services and the status of coverage.

Community leaders should as well be briefed on other indicators in order to gain their cooperation and support. Health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information.

It is a good practice that, when health staff give information and feedback to communities about coverage and disease outbreaks, and solicit community input for solving problems, community members themselves can contribute to identifying issues and defining solutions.

5.2.2 Community consultation and health service delivery

It also concludes that limited consultations between the health workers and community on when (time/dates) immunization exercises takes place; and not all the community members are mobilized to come for immunization in time.

Health workers carried out Immunization activities in some Sub Counties and consultation is done between the community and health officials on the immunization venues; and the agreed venues are adhered to. The Community participation is witnessed through mobilizing the population to go immunization, arranging and cleaning venues, carrying out home visits to remind parents who have not brought their children for Immunization to do so; and crowd control

5.2.3 How community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda

The study concludes that it's important to carry out monitoring and evaluation activities to guarantee the required steps that are being done by responsible people in order to reach the intended result about health in the community. The board should not recommend the actions a community to solve the health issues or who is accountable for what, but what it needs is an organized method to health enhancement that makes use of performance observing tools that will help them reach their goals.

The community monitoring program with the intention of facilitating effective participation of communities to monitor aspects of health services by demanding accountability for medicines' availability, deliveries, and for human resources to respect the rights of patients are paramount

The health workers should intensify health education and promotion activities aimed at sensitizing the communities on healthy nutrition. They must involve the community in all the levels of planning, implementation, monitoring and evaluation, such as; determining time/dates

of the education, educating fellow community members on nutrition, and rendering assistance to nutrition health educators.

5.3 Recommendations

The study made the following recommendation to the challenges highlighted by the findings on community participation and health services provision and delivery in rural areas are highlighted.

The health sector should train more people from the rural communities on matters of health and any new health intervention or challenges so that they will continue to be health extension workers in local communities.

The Ministry of health should also facilitate and encourage the local health extension workers (ToTs) to extend their training to other members of the community and also regularly meet with the communities to discuss health issues affecting them.

The health workers should intensify health education and promotion activities aimed at sensitizing the communities on healthy nutrition. They must involve the community in all the levels of planning, implementation, monitoring and evaluation, such as; determining time/dates of the education, educating fellow community members on nutrition, and rendering assistance to nutrition health educators.

The health workers should involve the community in family health care activities such as; determining dates/time for family health care education exercises, mobilizing all the community to come for family health care education and promotion, educating fellow community members on family health care, rendering assistance in one way or the other to family health care educators, and reminding their communities of the family health care messages previously taught.

The health work should organize disaster prevention and mitigation activities in Wakiso District and involve the community in all the stages of planning, implementation, monitoring and evaluation of the activities.

The health work should organize health care activities geared towards sensitizing the communities on chemical exposure risks and prevention messages such as snake bites, exposure

to agricultural chemicals, drug abuse, alcohol abuse, and son on; in Wakiso District. They should also involve the community in all the stages such as; determining time/dates and venues, educating fellow community members, and rendering assistance to health educators.

The health workers should intensify community involvement in sanitation education and promotion activities, specifically in the areas of; determining dates/time for sanitation health education. They also mobilized all the community to come for sanitation health activities, educating fellow community members on sanitation matters, and reminding their communities of the sanitation messages previously passed to them.

The health sector should intensify the immunization sensitization campaign in rural areas aimed at helping the rural population appreciate the role on immunization to their lives and communities; hence enabling communities to receive immunization activities with excitement.

More collaborative efforts should be put by the Ministry of Health and Communities in ensuring that the community is involved in immunization activities such as; determining date/time and registering the patients. They also made sure in making waiting areas more comfortable, transporting vaccines, transporting health workers, and continuing to visit vaccinated children as a way of monitoring the impact of the immunization exercise.

5.4 Suggested areas for future study

So the following suggestions will enrich this field with more knowledge;

- Impact of community participation on solid waste management
- Effect of decentralization on health service delivery

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APPENDICES

APPENDIX A: QUESTIONNAIRE

Dear Sir/Madam,

My name is **ANKUNDA CHARITY, 1161-06404-05026**, an undergraduate student of Kampala International University pursuing a Bachelor's Degree in Public Administration and Management. I am currently carrying out a study about **Community participation and health service delivery in local government: A case study of Wakiso District, Uganda** as a requirement for the award of a Degree in Public Administration and Management. I humbly request you to be one of the participants in this study and your cooperation will be of great importance to this study. Your answers will be kept with utmost confidentiality. Thank you very much for your time and cooperation.

INSTRUCTION: PLEASE TICK WHERE APPROPRIATE

Section A: Biographical Data

1. Sex

- a) Male
- b) Female

2. Age

- 20 -25
- 26-35
- 36-45
- 46-55
- 56+

3. Marital Status

- a) Single
- b) Married
- c) Divorced
- d) Widowed

Education level

- a) Primary
- b) Secondary level
- c) Vocational
- d) University

PART B: COMMUNITY PARTICIPATION AND HEALTH SERVICE DELIVERY IN LOCAL GOVERNMENT

Direction 1: Please write your rating on the space before each option which corresponds to your best choice in terms of level of motivation. Kindly use the scoring system below:

Score	Response Mode	Description	Interpretation
5	Strongly Agree	You agree with no doubt at all	Very satisfactory
4	Agree	You agree with some doubt	Satisfactory
3	Neutral	You are not sure about any	None
2	Disagree	You disagree with some doubt	Fair
1	Strongly Disagree	You disagree with no doubt at all	Poor

PART 2: COMMUNITY PARTICIPATION AND HEALTH SERVICE DELIVERY

Community planning and health service delivery		1	2	3	4	5
1	Community participation in planning for health programs and services is fundamental to effective and accessible primary health care					
2	Community leaders should as well be briefed on other indicators in order to gain their cooperation and support					
3	Health workers and community educators should be trained to strengthen their interpersonal communication skills so that they can give correct information					
4	The common problem is lack of community involvement in planning session dates and times					

Community consultation and health service delivery		1	2	3	4	5
1	There are limited consultations between the health workers and community when certain health services are offered					
2	Not all the community members are mobilized to come for health services in time					
3	Some health workers tend to be rude when community members try to consult from them					
4	Most community members sometimes ignore consultation about their health problems they face					

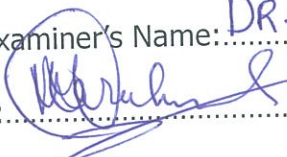
How community involvement in monitoring affects health service delivery in Wakiso District Local government, Uganda		1	2	3	4	5
1	Community monitoring programs help to monitor aspects of health services by demanding accountability for medicines' availability					
2	Involving community members in monitoring health programs within their communities help in influencing the health sector output with the limited resources					
3	There is need to involve community members in all levels of monitoring and evaluation, such as; determining time/dates of the education and educating fellow community members on nutrition					
4	It is important to monitor health activities in order to reach the intended result about health in the community					



**COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF POLITICAL AND ADMINISTRATIVE STUDIES**

Name of candidate: CATHERINE KIDEN GAITANO MARKO
 Registration No: 1163-06014-05820
 Department: POLITICAL SCIENCE & ADMINISTRATIVE STUDIES
 Programmes: INTERNATIONAL RELATIONS & DIPLOMATIC STUDIES
 Topic: THE UNITED NATIONS AND HUMAN RIGHTS ENFORCEMENT: A CASE STUDY OF SOUTH SUDAN

- | | |
|--|---------|
| 1. Title and problem formulation/objectives statement and definition/articulation/English Language | 16 -20% |
| 2. Organisation of material and logical presentation/sequence | 04 -5% |
| 3. Methodology used in data collection | 07 -10% |
| 4. Analysis of issues | 07 -10% |
| 5. Content and Relevance to course program subject | 07 -10% |
| 6. Application and /or theoretical linkage | 12 -15% |
| 7. Findings/ observation/comments | 13 -15% |
| 8. Conclusion/Limitation | 07 -10% |
| 9. Suggestion/or recommendation | 03 -5% |

Internal examiner's Name: DR. WILFRED McBARRY TARABINAH Marks: 76%
 Signature:  Tel: 0770614112 Date: 22/5/18

External examiner's Name: Marks:

Signature: Tel: Date: