THE ROLE OF COMMUNITY PARTICIPATION IN IMPROVING SOCIAL SERVICES TO RURAL COMMUNITIES IN UGANDA: THE CASE OF DECENTRALIZED HEALTH SERVICES IN BUTAMBALA HEALTH SUB-DISTRICT – MPIGI DISTRICT

BY

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DECLARATION

I do declare, that the work I have presented in this book is my own and that it has never been presented to any institution before, in part or in full for any academic recognition, and neither has it been published before in any form what so ever.

..... Date 30/10/06.

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APPROVAL

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DEDICATION

This work is dedicated to my beloved parents Mr. Yefusa Wabusa and Mrs. Efulansi Wabusa, who have struggled tirelessly to educate, and make my academic endeavors a success. May the Almighty God reward them abundantly.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF GRAPHS

LIST OF CHARTS

LIST OF ABBREVIATIONS:

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
DDHS	District Director of Health Services
DHMT	District Health Management Team
DHT	District Health Team
DOT	Director Observed Therapy
FP	Family Planning
H/Unit	Health Unit
HC	Human Center
HDI	Health Development Index
HIV	Human Immune Virus
HMIS	Health Management Information System
HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee
IMCI	Integrated Management Childhood Illness
IMR	Infant Mortality Rate
IST	In-Service Training
KM	Kilometer
MAP	Minimum Activity Package
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NGO	Non-Governmental Organizations
ORT	Oral Dehydrated Therapy
PFP	Practice- for- Profits
PHC	Primary Health Care
PNF	Practice-Not-Practice
Popn.	Population
SPSS	Statistical Package for Social Scientists
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants
U5MR	Under Five Mortality Rate
UDHS	Uganda Demographic and Housing Survey
UNESCO	United Nations Education & Scientific Organization
VHC	Village Health Committee
WHO	World Health Organization

ABSTRACT

The study mainly set out to analyze the role of community participation in improving social services to rural communities in Uganda. The researcher based the study on the fact that, most deaths in the community are due to conditions that could otherwise be preventable . This would be reduced through meaningful community participation and the belief was that decentralization would offer an environment for such participation. It was mainly a field survey of a sample county /Health sub-district in Mpigi District.

The main objectives of the study were to identify the effects of the management structures on community participation, to assess the quality of service delivered under a decentralized frame work, and to establish the impact of community participation on health service delivery.

A number of research instruments were used in the study ranging from questionnaires, interviews, observation and review of related literature. The Sampling techniques used were; simple random sampling and the stratified random sampling to ensure that all the population Sub groups were fully and objectively involved in the study.

The quality of health services was measured against their accessibility, affordability, availability to the population and the level of community awareness of the service.

The major findings of the study are that, though decentralization offered the opportunities for community participation, the community is still not fully involved. This is partly due to community ignorance plus the domination of lower level Health Management structures by District level representatives. The study also revealed that the quality of health services delivered is much higher in preventive and promotive services compared to the curative services largely due to the level of accessibility to these services

These challenges demand restructuring and strengthening the lower level health management structures, to ensure that there is capacity and capability to respond to health and social needs. Thus, attention should be drawn to processes that involve community participation but with special attention to vulnerable groups especially the rural poor, women and children.

Consequently, it is critical to re- examine policy at the national level so as to align it with overall population welfare. It means creating and operationalising a mechanism where PHC and activities in other sectors re-enforce each other.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

In the last three or so decades there has been increasing reference to the term "decentralization" as away of managing the Public Sector in both the developed and developing countries (smoke 2003). Indeed the classification of governments and constitutions into federal (decentralized) and unitary (centralized) forms had along and distinguished pedigree (Charlton 1986: 55-6). All governments in the world,, no matter how centralized, need, at the very least, to transfer responsibility for the execution of their centralized decided policies to regional or locally based branches or organizations.

In the case of Uganda, after she attained independence in October 1962, the post-independence governments experienced serious difficulties in delivering social services to her citizenry (Olum, 2000). These difficulties arose because the functions of Central government became increasingly inefficient, ineffective and inflexible (Tindigarukayo, 1988). Specifically, this crisis stem from the 1967 Republican constitution which was introduced after the abrogation of the 1962 independence Constitution, that had developed considerable powers to local authorities and granted them sufficient avenues to deliver social services like health care.

Until 1986, the whole Local Government structure in Uganda was highly centralized and all policy initiatives, directives and financial resources were controlled at the center. The legal background to this phenomenon can be traced in the 1967 local government Act, which centralized power in the hands of the Minister.

This is why after 1986, the Ugandan government, initiated a process of decentralization in local governance to promote and sustain popular democratic participation through a system of elected local councils (LCs). These LCs also aimed at re-invigorating the social-economic conditions of the people of Uganda and the country. This was further re-echoed by (Nsibambi, 2000), that "The Uganda government embarked on decentralization reforms with the aim of devolving functions, powers and services". It was also intended to ensure good governance and democratic participation, and control of decision making by the people. These efforts culminated into the enactment of the local Government Act (1997).

1.1 Background to the study

World wide there has been renewed attention to health sector reforms with particular thrust on delivery of services to the grass root populace. The Alma Ata declaration of Primary Health Care(PHC) in 1978, stimulated international recognition of the significance of primary health care(PHC) which was defined in a broader perspective to mean *The essential healthcare based on practical, scientifically sound, socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, at the cost that the country and community can afford to maintain at every stage of their development, in the spirit of self reliance and self-determination.* Thus PHC incorporates wider determinants of health including such elements as poverty, education and population, promotion, prevention and equity.

Faced with an array of political, economic and social problems; fragile institutions, heavy indebtedness and poor social indices, many least developing countries are implementing

PHC within the frame work of decentralization. Decentralization is perceived as a development model that can lead to progressive achievement of community health goals and poverty reduction by repositioning government policies to focus on responsiveness, equity and participation. Indeed in the late 1980s, under the Structural Adjustment Programs (SAPS), Uganda embarked on health sector reforms, with PHC as the policy cornerstone.

Decentralization of health service delivery to districts, was one of the major social reforms that took place in Uganda in the 1990s. The National Healthy Policy approved by cabinet(1992), further decentralized the health services within the district to the Health sub-district, to health centers 111, 11, and further to individual family level. . Delivery of health services in Uganda was decentralized in accordance with the constitution (1995) and the local government Act (1997), which specified the roles and responsibilities of different levels of government. The Act creates a structure of power from the central government down to village level.

The health care system in Uganda is structured more or less along the Local council (LC) system. The HSD defines the roles and responsibilities of the district health delivery system. Mpigi district is one of the Eighty Three districts in Uganda which comprises of four health sub-districts (Mawokota-South, Mawokota-North, Madu and Butambala) with a total population of 420,000 people. there are fifty six (56) health units and two hospitals (Mpigi District, Population office 2005).

Back ground of the study area:

Butambala Health Sub District is one of the four health sub districts found in Mpigi district. The other three are Mawokota north, Mawokota south and Gomba. Butambala Health Sub District is bordered by Mawokota south to the south east, Mawokota north to the north, Gomba to the south west, Mubende district to the west and the Masaka and

Sembabule to the south. It is made up of five Sub- Counties with a total population of87,958. There are 17,742 house holds in the HSD(National Census 2002).

There are seventeen functioning health units in, (both government and non government), distributed throughout the Health Sub District. Gombe hospital houses the head quarters of the health sub district. The health sub district has a number of private clinics and drug shops, the number of which is difficult to ascertain because some are not registered.

The top diseases affecting the Health Sub District(2001/2002) included; Malaria, Acute Respiratory diseases(not Pneumonia), IntestinalWorms, Acute Respiratory disease(pneumonia) and dental diseases in that order.

There are a total of 150 health workers in the 17 health units as at 31st, December 2002(HSD Super vision report, Dec.2002).

the main economic activity in the health sub district is subsistence farming. Other activities include pit sawing, charcoal burning and brick laying.

The health sub district, has Avery poor road network, which makes it difficult for the population to easily access health services from the health units. This is worsened by high poverty levels of the grass root people.

Table 1: Showing health indicators in Butambala HSD

INDICATOR	RATE		
	Butambala HSD	**Mpigi district**	**Uganda**
Population/Hospital bed	1:773	1:2774	1:858
Population/Doctor	1:24,144	1:41,023	1:18700
Population/Nurse	1:3577	1:8567	1:4,300
Infant Mortality rate	97/1000	97/1000	97/1000
Maternal Mortality	506/1000	506/100	506/1000
Safe water coverage	50%	50%	47%
Immunization coverage	83%	50%	80%
Latrine coverage	45%	45%	55%

Source: HSD progress reports 2005

1.2 Statement of the problem

The population of Uganda is estimated to be about 26.4 million (2004 projection), 86 percent of which lives in rural areas. The infant Mortality rate (IMR) is 88 per 1,000 live births, the Under Five Mortality rate (U5MR) is 152 per 1,000 live births, and the Maternal Mortality rate (MMR) is 499 per 100,000 live births (UDHS 2000). The Infant Mortality and the Maternal Mortality rates are therefore, un acceptably high.

According to the health indicators in Mpigi district, the patient-doctor ratio is 1:41, 023, and the Nurse-Patient ratio is 1:8,567 both of which are still very high and the average distance to a health unit is 7km (World Population Day Special Issue 2004). This makes accessibility to the health personnel and health units difficult. According to the 2002, Burden of Disease Study in Uganda, over 75% of the people die prematurely due to preventable diseases which include malaria, diarrhoea, and maternal conditions

In the light of the above obtaining health situation in the country, the government of Uganda embarked on the decentralization of health services as one of the millennium development goals. The main aim of decentralizing health services is to take the health services closer to the grassroots population, who otherwise had been left out of the consumption of such services due to the fact that most of the health services are located in urban areas, most especially, Kampala.

It is therefore important to critically analyze the impact of decentralized health services on the livelihoods and development of rural communities with particular reference to Butambala Health sub-District (county) in Mpigi District.

1.3 Purpose of the study/ general objectives

The purpose of the study is to analyze the role of community participation in improving social services to rural communities in Uganda.

1.4 Specific objectives

1. To identify the effects of the Health management structures on community participation.
2. To assess the quality of health services delivered under decentralization.
3. To assess the impact of community participation on health service management.

1.5 Scope of the study:

The scope of the study included; the period over which the study was under taken, the subject that was covered by the study and the geographical area within which the study was under taken.

1.5.1Time Frame: The research study was limited to a period (1994-2006), the period in which decentralized local governance took effect in Uganda. The research study was carried out over a period of one year(from July 2005 to July 2006).

1.5.2 Subject scope

The study looked at development indicators in the Health Sub-district. Emphasis was put on the management structures created by decentralization; The health services provided by the health units within the district; The level of community participation; The accessibility and affordability of these services to the population and ;The diseases that commonly affect the community of Butambala Health Sub District.

1.5.3 Geographical Scope

The study covered Butambala Health Sub-District, which is one of the four Health Sub-districts in Mpigi District. According to Mpigi district population office 2004, Mpigi district has a population of 420,000. Butambala HSD has a population of 89,755, Mawokota south 122,411, Mawokota north 71,570 and Maddu HSD with the population of 136,264. The head office of Mpigi district is based at Mawokota north HSD, with Gombe hospital as the district Hospital, located in Butambala HSD.

1.6 Significance of the study

The significance of this research is to contribute towards creating a health service management system, that fully considers the views of the community members, and that will maximize utilization of the different potentialities, that exist within the grass root population, towards improving their livelihoods.

It is expected that this exposure would lead to acquisition of a sound understanding of the character and scope of Uganda's decentralization policy and programme, and how the programme implementation contributes to improved health service Provision, democratic community participation, accessibility to health services and the country's overall development within the broad frame work of the concept of health service delivery to the rural populace.

1.7 Hypothesis of the study

Decentralization of health services is likely to have a significant impact on the social services of the rural communities.

1.8 The Conceptual Frame Work.

Participation should be taken as a key issue in any development efforts. This is based on the fact that, a big population of the community die from disease conditions that could otherwise be prevented through the efforts of the people themselves. Most of the deaths result from the inaccessibility to the health personnel given their limited numbers.

With this concept of development and given the increasing numbers of the population, it is evident that, participation can help to bring more meaningful development to more people, given the enormous potential, it can exhibit. This potential can be tapped through, the establishment of institutional frameworks, decentralized frameworks and processes which involve the people in decision making, in issues that affect their livelihoods.

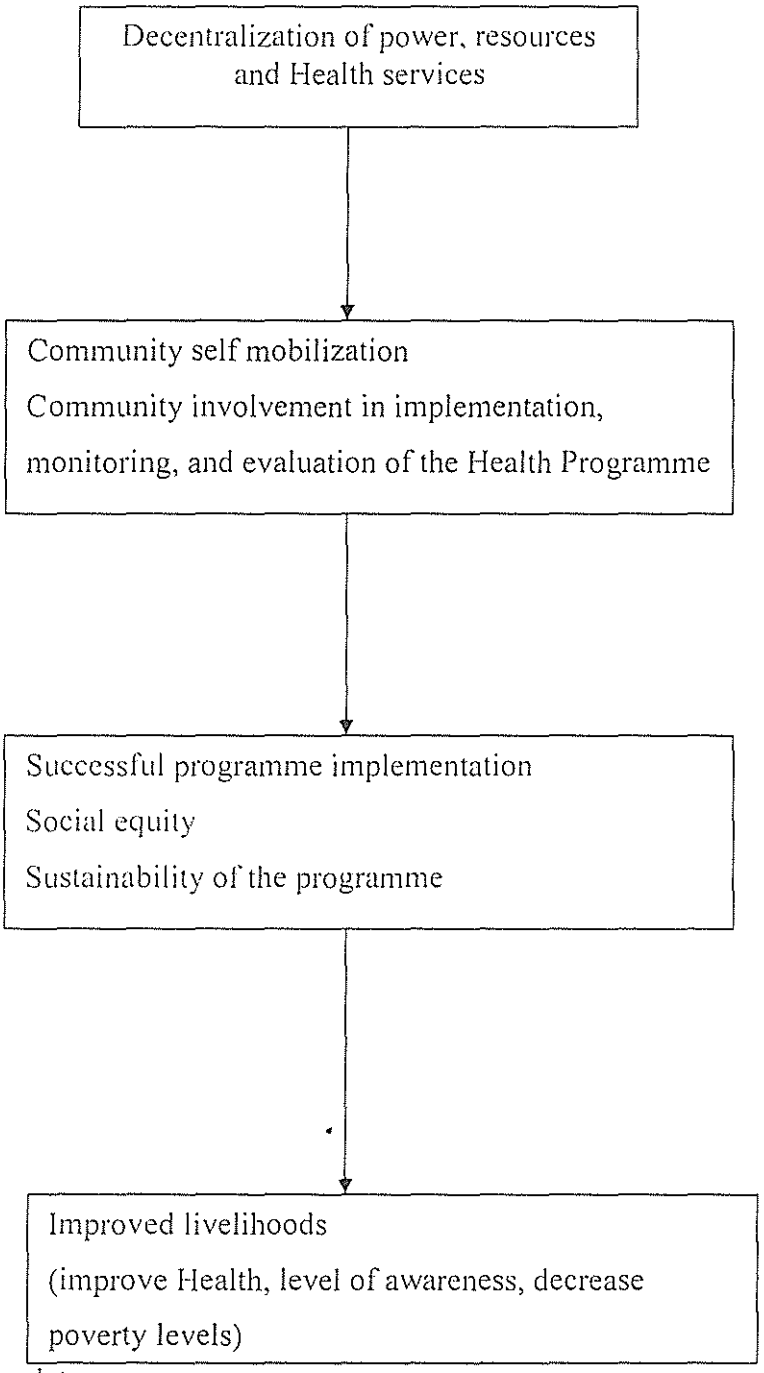
The concerned institutions, should involve a critical and meaningful stake holder consultations, from professional experts to the people actually affected.

All in all, participation, implies nothing less than transformation in traditional approaches to development, to involve all stake holders.

Given the multi-sided meaning attached to development, it is , therefore, important to always consider participation, in all development attempts such that, it is tackled as per the understanding of a particular group. Recent experience, for example, in Uganda, especially to do with the health challenges in the country, show that a turn to indigenous knowledge is one of the best ways to improve the livelihoods of the people. Take into consideration, the use of herbs, in the struggle against HIV\AIDS, which has sent positive signals over the strength of indigenous knowledge.

In other words, the requirements of development , turn out to be more tolerant of cultural and institutional variety, than we thought on the basis of our limited prior experience.

Chart 1: Conceptual framework



Source: Primary data

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In recognition of the available existing work already researched on in the area of study, the researcher reviewed the works of other researchers. The review of literature required time and effort to identify, locate and analyze existing documents and information on the subject with the objective of revealing contributions, weaknesses and gaps. The review of literature provided ideas, theories, explanations and methods of research valuable in formulating and studying the problem.

The literature reviewed, is in line with the objectives of the study. It mainly focuses on how health management structures impact on community participation; and how it eventually affects the quality of health services delivered and overall community development.

2.2 Uganda's Decentralization Policy, the local Government Structure and Health Service Delivery

Uganda has been pursuing a major decentralization programme since the late 1980s. Ahighly centralized state is gradually turning into a decentralized state following the transfer of powers, functions and services from the central government to local councils (Nsibambi 1998). The implementation of decentralization is a subject of much debate amongst politicians, public servants, civil society and scholars. Decentralization is providing the frame work within which government is promoting good governance, improved service delivery and poverty alleviation. Local governments are delivering

more services and are increasingly taking on the role of promoting the welfare of citizens and alleviating poverty in their jurisdictions (Museveni 1992).

2.2.1 The Local Government Act 1997:

The Local Government Act defines and describes the various levels of governments, their creations and how they relate to each other. The law also defines and clearly sets out roles of central government and the local governments. It also clearly defines the revenues reserved for local governments, and which local government, is to collect which revenue. It sets out how revenue between local governments is to be shared out as well as how the central government is to share revenues with local governments (Richard 1999). Lastly, this law devolves certain functions for the central governments to local governments.

According to the local government budget analysis 2002/2003, while the devolution of functions and responsibilities has worked well for the center to district relationship, the devolution of responsibilities for the district to lower local governments has not been as smooth. The reason for this could be: the entities here are very small and the tendency to overlap is greater at this level than the central-local government relationship; the revenue sharing between the district local government is constrained by the fact that the amounts are small and when divided further to lower local governments, their effectiveness is greatly reduced (Helmsing 1995). The sharing of revenue as detailed out under the local governments Act has meant fragmentation of scarce finance and the end result has meant that what is left at the end is too small to be of real use.

2.2.2 The HSD System in Uganda:

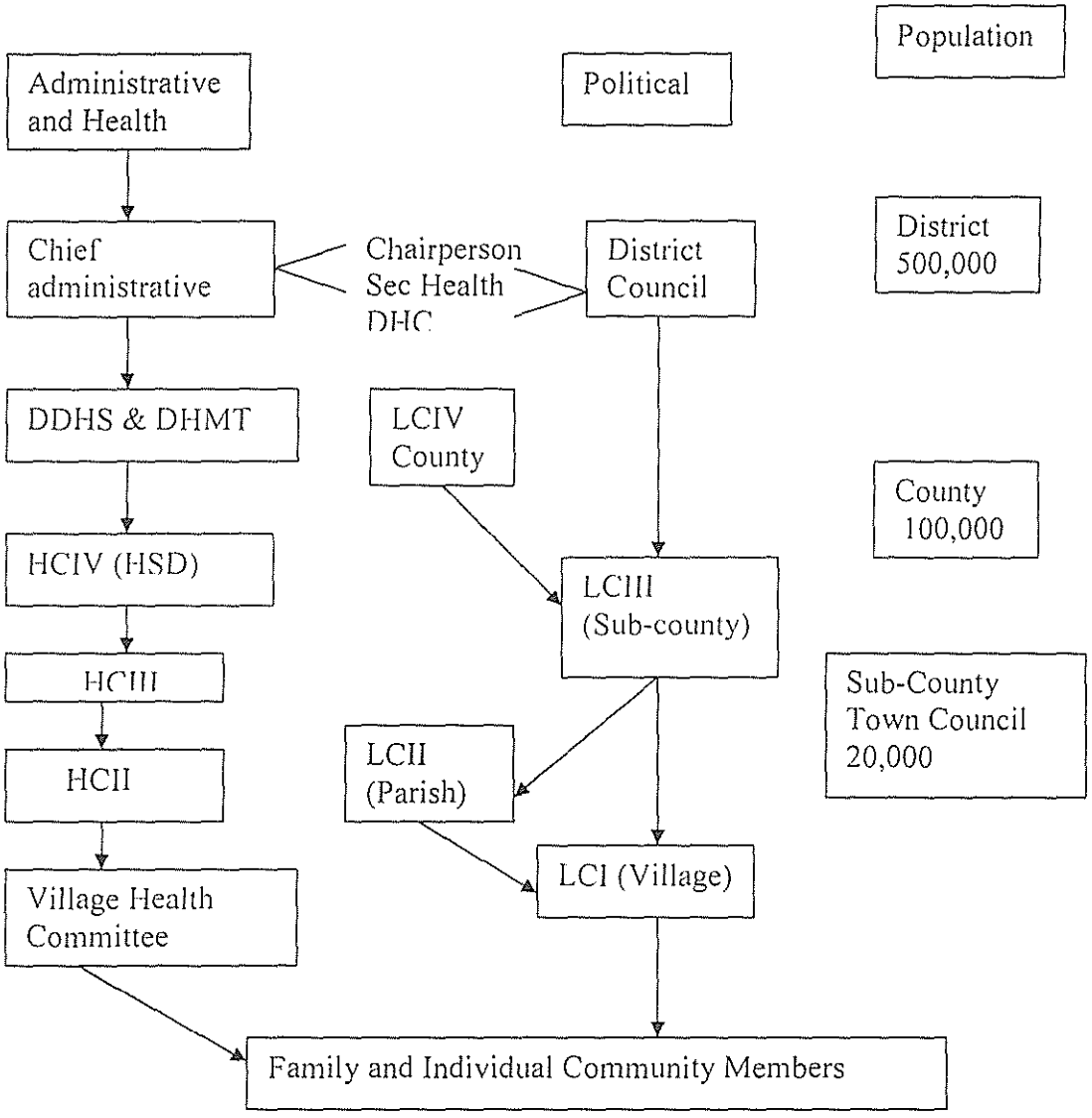
The Local Government Act(1997) creates a hierarchical structure of power from the central government down to the village level. At the District, there are elected local Councils (LCs). The district LC. V is the basic administrative unit. Below it is the LC. IV at the county level. Administratively, LC IV is of little significance. Next to LC. IV is LC.III located at the sub-county level. Relative to LC. IV, this level is politically significant. It is the next planning unit after the district (GOU, 1996).

The health Delivery system in Uganda is structured more or less along the LC. System. The Ministry of Health devolves to the district. Overall, is the district health committee which is the overall policy advisor (GOU, 1998). There is the Director of District Health Services (DDHS) who is over sighted by the district health management team (DHMT). These operate at the LC V level or at the district level.

At the LC. IV or county level is the health sub-district (HSD) and the district health committees (DHC). However, at the LC. III and LC.II are the Health centers (HC III) and HC II). At the lowest administrative/political level are the village health committees and finally the family and individuals in the community.

The provision of health services includes the stage of policy making, implementation, monitoring and evaluation (Smith 1987). The role of policy making regarding health service provision in Uganda has remained primarily under the central government both in the past and the present. It is usually vested in the ministry of health (Kisamba 1998). Policies may be formulated in consultation with other closely related ministries.
In addition, local governments may formulate subsidiary policies but in line with national policies (Nsibambi 1996). The philosophy of decentralization is to formulate policies with the participation of the masses (Lubanga 1996).
Under the decentralized system, monitoring and evaluation roles are no longer a monopoly of central government experts and extension staff. Although the ministry of health maintains the primary roles of supervision, an increasing role is being ascribed to the users of health services. Consequently, there is increasing advocacy for participatory approaches to monitoring and evaluation of health services (Kagina, 2003)

Chart 2 : The district of Health care delivery system



Key
CAO = Chief Administrative Officer
DDHS = Director of District Health Services
DHMT = District Health Management Team
DHC = District Health Committee
HSD = Health Sub-District
HC = Health Centre

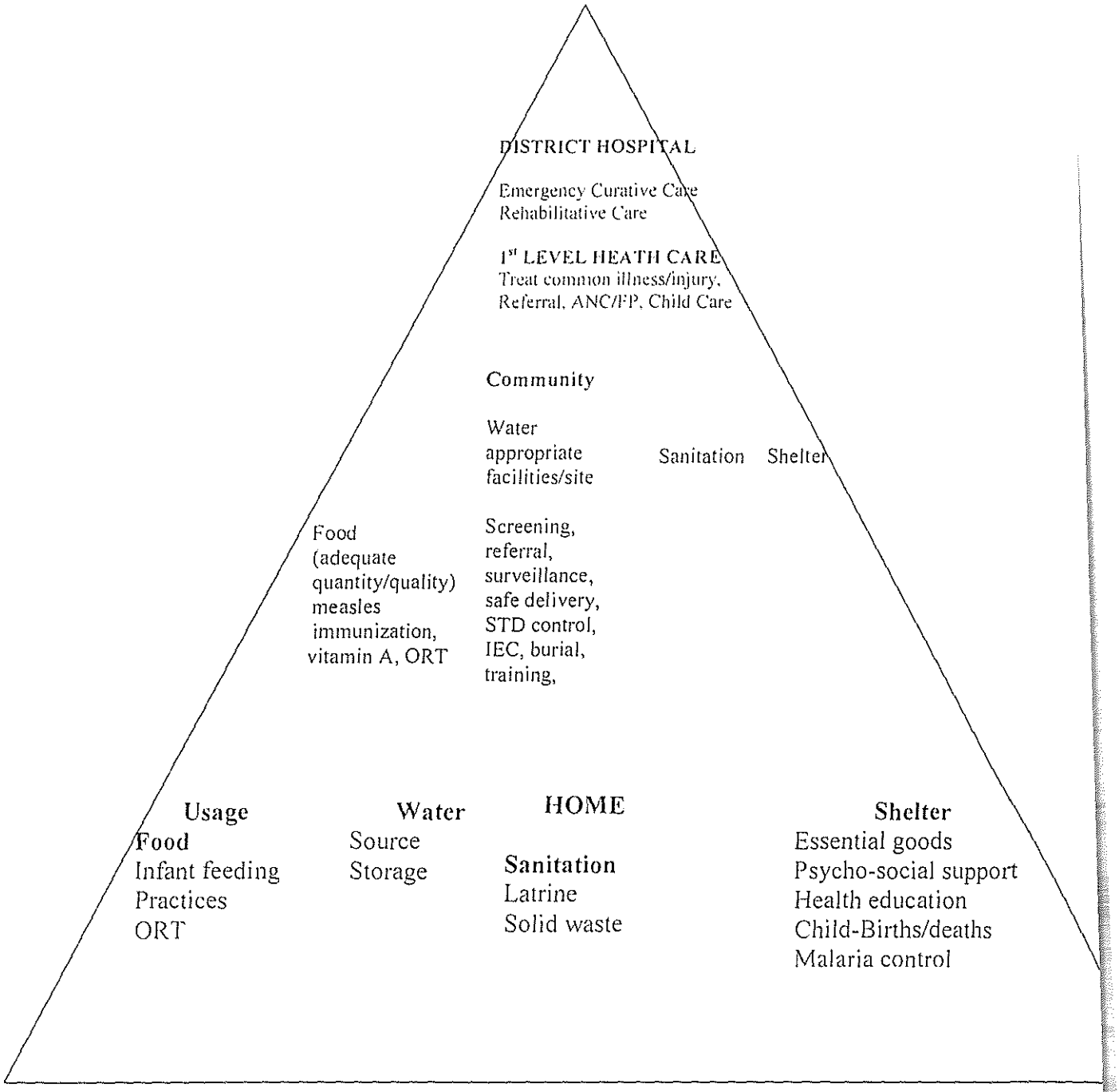
Source: Ministry of Health, mid term review report 2003

2.2.3 The Role of the Health Sub-District (HSD).

The Health Sub-District (HSD), according to Bagambisa, et al, (1999), is a new creation at the constituency level or the county whose population is about 100,000 or more people. The HSD defines the roles and responsibilities of the district health delivery system.
The district is responsible for providing overall leadership, planning, supervision of District Health Services; compiling the HSDs' plans and integrate them, then submit them to the District council for approval; monitoring and evaluation of district health services and co-ordination with the district and the MOH officials.

On the other part , the HSDs are responsible for operational plans and management of the health services delivery; implementation; monitoring and supervision of all the basic services in the HSD; offering emergency surgery and treating referral cases from lower health units. The roles and responsibilities of a health sub- district also include the preparation of health activity implementation plans consistent with the over all district and national health plans; budgeting, managing and accounting for resources allocated for health services, provision of essential clinical services and to act as static units for disease prevention and health promotion activities like immunization, health education and nutrition (Health Sector Strategic Plan (HSSP 2000). According to Lule (2003), different activities are expected to be carried out at the different levels of the HSD health facilities.

Chart 3: Pyramid of Primary Health Care



Source: The John Hopkins and IFRC Public Health Guide

2.3 The Concept of Primary Health Care (PHC) and Community Participation in a Decentralized Frame Work

World wide there has been renewed attention to health sector reforms with particular thrust on primary health care (PHC) as an a venue for delivering services to rural communities with their full participation.

The Alma Ata Declaration o 1978 stimulated international recognition of the significance of primary health care which was defined in a broader perspective to mean, "the essential health care based on practical, scientifically sound, socially acceptable methods and technology made universally accessible to individuals and families, at the cost that the community, health sub district and county can afford to maintain at every stage of their development in the spirit of self – reliance and self – determination. PHC therefore, forms an integral part of the country's health system of which its central function and main focus is the overall social and economic development of the community.

Decentralization is, perceived as a development model through which the goals of PHC can be progressively achieved; and through which poverty can be reduced by repositioning government policies to focus on responsiveness, equity and participation (Helmsing 1995).

Too, often, the majority of those living in the developing world, of which Uganda is part, appear to be incidental to development rather than its focus. Ultimately, all development strategies should be measured by the benefit they bring to the majority of citizens, while the value of particular development tactics should be measured by the extent they will contribute to that end, (Makara, S. 1998). Governments should therefore review their priorities and distribution decisions, focusing on basic human needs and placing primary emphasis, on enforcing measures that promote community participation in all development programmes including health services delivery. To deliver health services effectively to rural communities, health workers must therefore, acquire health understanding of approaches that promote community participation.

Community participation may entail risks to governments, particularly none democratic ones. The current wave of globalization, offers an opportunity to build genuine community involvement, however, even in open societies; their may be vested interests (Cheema 1983).

In such cases, wide public involvement in decision making is often neither easy nor efficient, particularly, when there is no clear social consensus on key issues much remains to be done and learnt in the practice of community involvement. In real practice, however, there is a conflict between the health workers and community members. Being non professional, the professional group in most cases does not acknowledge their legitimacy, and this is generally a set back towards community participation in the provision of services.

However, it is because of the existing legal and policy framework for citizen participation at local level that Uganda is hailed for having one of the most ambitious decentralization programmes in Africa (Dunleavy 1986). On the other hand, while the current frameworks have created avenues for community participation, and local accountability, (Rugambwa, 2004), the argument is that decentralized administration can be as bureaucratic as centralized administration and even oppress the people more closely.

While there is general agreement on the importance of community participation in health development, much remains to be done to implement the concept. Passive participation, in which the public utilizes the services and contributes money, materials, labours, is fairly wide spread (charton 1986). Active involvement, in terms of the planning is still un common.

According to Schmidt (1994), conventional health planning is not conducive to community participation, it tends to be a top – down process, with a group of experts identifying "priority" health problems and then deciding on programme activities to solve them.

Community participation is preluded when health priorities and solutions, including the types of health workers and services needed, have been decided at the central level. In practical terms, decentralization of responsibility to communities and local health authorities runs counter to the perceived self – interest of most health decision makers (Republic of Uganda 1997).

Problems also exist within communities themselves. Lack of cohesion, the scattered nature of the populations in rural areas and social stratification (Kisakye, 1996) are all barriers to effective community participation, in one way or the other.
There are often reactionary forces within communities that try to maintain existing power relations, making community participation difficult. Such problems manifest themselves even in simple tasks such as, the selection of village health workers and community health volunteers. However, given time, the communities are able to over come them; while the wrong village workers may be chosen the first time, it is unlikely to go on happening (Kisubi, 1996).

According to Nsibambi (1992), the frequent lack of organizational structures, such as village councils and community clubs, is an obstacle to community participation. Even when such structures do exist, they usually have to be developed before any genuine participation can begin. The scope and content of community participation will, however, vary from country to country; for example; while the social control of the health services may be possible through political structures, like the local council system in Uganda, in some countries it may not be possible or desirable (Munyonyo 1999). We can therefore, conclusively say that attention to social justice is vital if development is to produce positive results and if society is to equitably benefit from the deliberations of any development effort or activity. Primary Health Care, under a decentralized health frame work, appears to be most suitable for achieving community development.

2.3.1 PHC as a Development Strategy and as A Service

There is a general agreement of PHC principles as put forward by the Alma Ata declaration. PHC should be situated within each country's setting addressing the main health problems in the community, providing promotive, preventive, curative and rehabilitative services (WHO, 1978). PHC is therefore, both a health development strategy and a level of health services (Kekki, 2003). The achievement of these would require inter sectoral collaboration and community participation. This diversified action allows us, to view community development from a multidimensional perspective thus, economic, political and cultural.

These proposals could be reduced to four principles: equity; community participation; principles; intersectoral approach, and; appropriate methods.

Equity requires that services should be physically, socially, and financially accessible to every one, paying particular attention to the poor and vulnerable groups, like the children. the disabled and the mothers. Meaningful community development should be in such away that, cultural and economic progress is as widely accessible as possible and not concentrated in certain localities, sectors or groups of the population (Kasumba, 2003).

To be effective, the health sector needs to get maximum involvement of the community and individuals: creating and maintaining a healthy environment, maintaining and sustaining preventive and promotive values; sharing with professionals, planning,organizing and implementing health programmes, and managing health units.
For true participation, communities need to be better informed on alternative choices and their implications (Nsibambi, 1997). Community participation can be achieved through meetings, which may focus on three main issues: what the problem is; what the community itself can do about the problem; and how the health team can assist the community in their efforts to overcome the problem. Meaningful community participation, therefore, entails strategies for community empowerment, for instance through a deliberative process of mobilization and sensitization; eventually leading towards a mutual understanding about the roles and responsibilities of the community on

the one hand, and the health sub district health team on the other (Byaruhanga 2002). This can be a time – consuming process but an extremely important one, in that, the more that community is aware of what is involved, the more positive it will be towards community health programmes and the more development will be achieved in such a community. Jamal, (1998), remarked that, when the people feel that, they have the freedom to think, act and relate to each other, they take a lot of responsibility and eventually they will play a leading role towards their own development.

Since health affects and is affected by other sectors (education, agriculture, water, transport, housing, industry, public works), its effectiveness depends on strong inter – sectoral collaboration in a well coordinated manner. In the current Uganda decentralized health delivery framework, however, attainment of full harmonization between the actors in health care, between the different players is still problematic given that different players have different mandates, visions and missions (Hewavitharana, 1997). For instance, lack of harmonization of government projects has resulted into; contradiction and duplication of health messages; confusing the community; rivalry among projects / programme and inefficient use of resource (Kitilla, 2003). Other players view this process as if it is intended to swallow their own initiatives and make the initiatives of PHC as the "gospel" truth, which they think may hinder their own initiatives (Bird, 1999).

It is also important that appropriate methods are used in health care. PHC requires a blend of local and referral methods. Health care providers should be trained to deliver services applying the most suitable quality technology at all levels. In essence, PHC is a combination of facility-based services (curative and rehabilitative) with promotive and preventive public health interventions.

PHC, therefore, addresses health as a state of complete physical, mental and social well being. Not merely the absence of diseases or infirmity (WHO 1978 Alma Ata). Ideologically, PHC underpins Universal access and coverage, the site of first contact –

that is right from grass root community level; coordinated and integrated services (WHO, 2003).

World wide, many countries have implemented the Alma – Ata principles with varying degrees of success (WHO, 2003). Generally, the implementation is being done through the decentralized model of development.

Decentralization as a political act involving the transfer of power and authority from the center to lower levels (Rondinelli, 1983) takes four forms; devolution delegation, and deconcetration (Rondinelli et al, 1983; mills, et al 1990).

Devolution is viewed as the handing of some authority to local offices of the ministry of health (MOH) via administrative means (Conyers, 1981). Delegation, refers, to the transfer of managerial roles for defined functions but is indirectly controlled by the MOH (mills, et al 1990). Privatization involves the transfer of Government functions to voluntary and profit making organizations while de-concentration is a form of administration that does not transfer authority (mill et al 1990).

Several benefits are perceived to flow from decentralization; efficiency, participation, equity and accountability, (Thomas, 1990). Others argue to the contrally (Collins 1994); Borden and mookherjee 1998 and 2000). See details as discussed under the interrelationship between decentralization and development

Literature cites Srilanka, Kerala, Brazil and Bangladesh as success stories in the implementation of PHC.

These cases exhibit strong political commitment to PHC and decentralization, strong social movement and thus deeper community involvement.

Also they have strong health care systems; and PHC is implemented as an integral part of a whole system strongly interwoven into the wider inter – sectional activities organized to address abroad spectrum of population welfare, in which effective provision of promotive, preventive and curative care is enabled.

A health system in this research study; refers to a complete unit, formed of very diverse interacting and inter-dependent partners working towards a common goal, that is, attaining a health population and overall community development (Bhatia, 1999).

According to Mill et al (1990), however, the distribution of power between different levels of Government remains knotty. Potential losers are reluctant to hand over to those who stand to gain. Such power struggles can undermine the reform process. The division of authority for budgetary management is important in many countries, although recurrent budgets have been devolved to districts, development budgets remain within the ministry of health (Maureen, 1998). In essence, fiscal decentralization has been limited. Consequently, the district ability to improve efficiency and effectiveness of service delivery is constrained.

Moreover, decentralization in itself does not guarantee responsiveness of service delivery to local health needs because local elites are just as likely to pursue their own interest as central level officials and politicians (Collins, 1989)

2.3.2 Integration of Health Programmes under a Decentralized Framework:

According to wood (1998), the individual patient, family and community must understand how to use the health care system when they need it which requires the system to appear simple, friendly and accessible. Communities should be involved in defining their needs and planning and should know how to meet them while fitting in the district / HSD national health policies.

Before inter-sectoral collaboration can be a reality, different sectors, such as health, education and agriculture; should work well together.

It is also essential that the different departments of the health sector themselves also work closely together.

Technical and administrative staff must be cooperate, general and specialist services must be coordinated, research and relevant medical industries need to be incorporated in the health services (Munyonyo (1996).

Intersectoral collaboration will ensure that sectors with a direct influence on the health of the people are brought in action, for instance; curricular development should include

information about PHC, agriculture emphasizing better farming methods to improve food production and nutrition, water communication to allow easy access to health facilities, information and broad casting, for creating awareness of health concerns and carrying out health education through mass media. Wood, (1998), argues that recognition of the value of helping communities to formulate their own plans, incorporating their own activities, is very important, where communities contribute to the planning, implementation and evaluation of development programmes.

2.4 Interrelationship between Poverty, Health and Development.

According to the results of two participatory poverty assessments conducted in Uganda (Deepa, 2002), the poor define their status in terms of lack of basic needs and services, such as food, clothing, bedding, shelter, basic health care and education; powerlessness and inability to influence ones conditions, social exclusion; poor governance, low community status or affluence, and lack of knowledge or awareness.

Apart from these common elements that every one seems to agree on, there are others that tend to be emphasized by different groups in different social economic circumstances (we need not go into those details in this study).

The poor, who constitute the majority, live mostly in the country side and lack or (have minimal) access to land, capital, employment, education, health services, safe water, information and affordable energy sources – all of which subjects them to poor health conditions (Jenkins (1999). They also tend to have very little opportunity and capability to influence decision that affects their locality and lives.

They often live in conditions of insecurity, are subject to injustice and human rights abuses, have large families and tend to damage the environment through poor agricultural and cooking practices (Caroline 2000).

Women constitute the majority of the poor and are more likely to spend less time in school due to early marriages, accidental pregnancies and over whelming domestic chores including fetching water over long distances, preparing food, engaging in

agricultural activities and looking after the sick. They are also liable to suffer health problems due to cooking in un healthy environments (Caroline 2000). More demand is also made on them than men in situations of high HIV/AIDS prevalence, because of a large number of the sick and orphans they have to be looked after, (Deepa, 2002). Also, due to their lower exposure to education opportunities and to the large amounts of time they spend on domestic chores, women are less likely to participate in public affairs even within their own localities.

Reducing poverty, therefore, involves undertaking several related interventions whose overall objective is to improve peoples well being, (Kisubi 1996). These include raising the incomes of the poor so that they can have access to social services (health, education, water, housing) to improve the quality of their lives, removing all constraints that prevent them from engaging in productive life and enabling them to live as full members of their communities (Nsibambi,1998).

A health, knowledgeable population is essential for increased production, which is a pre requisite for a nation's growth and development. A healthy environment, improved reproductive health, easy access to safe water, and improved agricultural services and information are essential for reducing women's domestic constraints, allowing them to attain better education levels, and enabling them to participate more effectively in public affairs (Hoetz, 1999)

Decentralization and local governance are key factors in bringing about this. Decentralization that promotes participatory and inclusive decision making is likely to lead to amore effective Identification of local problems and to better allocation of resources among competing local priorities than centrally determined interventions.
The eradication of poverty therefore, requires development in which access to the benefits of economic progress is as widely available as possible and not concentrated excessively in certain localities, sectors or groups of the population. Economic progress does not by itself mean that the benefits will be equitably distributed, that the poor and most vulnerable will be protected or that greater equality of opportunity will be pursued.

Attention to social justice is vital if development is to produce positive results and if society is to develop in a balanced way (Sebahara, 1998). If economic opportunities are focused exclusively on urban centers, while rural life is degraded and destroyed, turmoil and social disintegration will be the price of change.

If social protections are only available to the urban minority and lack of access overall translates into a practical; lack of rights, development can only be a relative term (Sebahara, 1998). Development and spending priorities, therefore, need to be broad-based, equitable and inclusive (Stella, 1998).

For a long time, one of the development debates has taken place concerning diseases. This is most especially so in the third world where health is largely affected by poor policy, individual behaviour, negligence, ignorance and reluctance among others. This leads to poor hygiene and sanitation, poor living conditions, persistent health failure and rampant disease spread which both retards development and makes these poor nations of the world to use their scarce resources amidst various priorities; for example, road construction to improve communication versus mass immunization of a killer disease or mass sensitization on a disease out-break. Take for instance the cholera outbreaks in Uganda that occur almost whenever, there are heavy rains (Stella, 1998).

From this review, it is clear that the challenge ahead of these nations is such a large one and involves a lot of need for both bottom-up and top-down planning, if lasting solutions have to be reached at. It is very evident though that this development obstacle is not only a problem or third world countries but affects the developed world too, in several ways, for example; the donor community instead of donating funds to build more schools will send funds to help in the fight of a scourge/out-break in the third world.

Such money will not work towards creation of more jobs/employment, enlarge the tax base, but will be used for consumption in the treatment of diseases.

2.4.1 The Interrelationship between Decentralized Management Structures, Citizen Participation, Accountability and Development.

According to maw hood (1996), decentralization is a concept that suggests the hope of cracking open the inner central bureaucracy, curing managerial constipation, giving more direct access for people to the government and a government to the people, stimulating the whole nation to participate in national development.

The rationale for decentralization in Uganda was political and the main consideration leading to the decentralization that is being implemented was the need to reverse the centralization of government introduced by the constitution of 1967 (Villadsen, 1996). The constitution at independence in 1962 established a highly decentralized system combining federalized with semi- federalism and unitarism.

The independence constitution was abrogated in 1966 and in its place a new constitution which centralized powers was enacted. For purposes of this research study, centralization is the concentration of powers in a single area, usually the country's capital (Nsibambi, 1996). So it was that the re-introduction of democratic government became an important pact with the people of Uganda and one of the main features of the 1995 constitution of Uganda.

Because of the will and commitment to restore democracy, the form of decentralization that has been adopted by Uganda is devolution. An administrative decentralization or deconcetration would never have addressed the problem of centralization that was ushered by the 1967 constitution (Namara R.B 2003). Devolution, in contrast to administrative decentralization, is not concerned primarily with improving service delivery, removing democratic bottle necks and reducing delays but with giving citizens or their elected representatives, power in public decision making. Devolution, because it transfers power to the people, reduces central government control thus leading to the formation of "local-level" governments.

Local level government, in this study shall refer to any sub-national level of government entrusted with the authority to perform certain functions affecting a specified political boundary. Such functions may be administrative, political and financial or any others as defined in roles and procedures governing the establishment of such local governments. A local government may be regional, district or health sub district and the lowest is at grass roots or the village level (Kisamba 1998).

It is generally agreed that promoting democracy at the local level holds the key to reducing poverty, improving service provision and successfully undertaking other initiatives that fall under the general rubric of development (Conyers, 1983). Good local governance refers to the interplay of all the elements in the decentralized setting, that may be, political, managerial and financial, for purposes of bringing about the assured transformation for the development or the benefit of the people or community. For example, constitutionalism introduces checks and balances and reduces excesses and abuse of offices; justice and rule of law create a conducive environment for economic growth and investment; good leadership generates better pro-poor policies and improves performance; popular participation leads to better prioritization and local ownership of development programmes. Transparency and accountability in public office, ensures that resources reach their intended targets and an informed citizen is capable of holding public officials to account to ensure that the policies they pursue reflect the general will of the people, and that they are genuinely intended for meaningful community development.

Uganda's decentralization policy according to Nsibambi (1996), was assigned among other things to transfer real power to local government and thus reduce the work load on remote and under resourced central officials; bring under control (political management and administration) the delivery of services to the local people; to improve effectiveness and accountability and responsible use of resources by establishing a clear link between the payment of taxes and the provision of the services they finance and lastly, to improve the capacity of local councils to plan, finance and manage the delivery of services to the communities. Much of the current cause of under development to African countries is

systemic corruption which robs the nations of vital resources for national development (Mutibwa, 1992)

Decentralization and local governance are therefore, key factors in creating community development.

Decentralization that promotes participation and inclusive decision making is likely to lead to more effective identification of local problems and to better allocation to resources among competing local priorities than centrally determined interventions (Museveni 1992). Citizens, can not however, participate in public affairs, even over matters that affect them directly, unless, they are empowered.

Empowerment, in this study, refers to the process through which peoples freedom of choice and action is expanded to enable them have more control over resources and decisions that affect them (conyers, 1993).

This can be achieved through all inclusive, participative management structures. People at the grass roots however, lack sufficient organization, which always exposes their agenda to risk of elite capture. In other instances, politicians have adopted "co-participation" with local communities, as away of responding to community priority needs in order to get re-elected (Rondinelli 1981). This has generated greater citizen trust in several countries such as Columbia, Bulgaria, Croatia, Romania, Serbia, and Ukraine. Langseth, (1996), notes that decentralization brings decision making much closer to the population, permits better communication between the local leaders and the population they are supposed to lead and eventually creates a situation conducive to local decision making, founded on local options and circumstances.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents all the methods used to collect data from the field. It also includes an in-depth analysis and description of the entire process of the study. The research study employed a variety of sampling techniques ranging from; questionnaires, interviews, Focused Group Discussions. The sampling designs used in the study were; simple random sampling, and stratified sampling technique.

3.1 Research Design

The study employed a sample survey of a rural county. It was both an analytical and descriptive study. The assumption was that by analyzing the characteristics of this sample, the researcher could make certain inferences about the general characteristics of the decentralized health service delivery system in Uganda. In this study therefore, Butambala Health Sub District (HSD) is representative of all rural HSDs in Uganda.

The study made an analysis of the health management structures and how they affect community participation in health service management. A critical analysis was also made on the linkage between community participation and the development of the rural population/community served by this HSD.

The study carefully described the health services provided by this Health Sub District to the community by analyzing the strategies of delivering these services and how all this affects the development of the study area population. A thorough description of the roles played by the various stake holders was part of the study.

The study applied both quantitative and qualitative techniques. It was quantitative because the responses were compiled and computed statistically and the results were accordingly presented using frequencies and percentages in tables and figures using Micro soft Excel. The study was qualitative because, the different views of the respondents tended to highlight the various perceptions conceived by the different respondents.

3.2 The study area and study population:

The study area was Butambala Health Sub-District in Mpigi district. The study population was made up of all cadres of health workers, and all health unit in-charges in the functioning sixteen health units in the health sub district. Community leaders at various levels of local governance, from LC IV down to LC 1, were part of the study population. Most importantly the community members, both men and women were another significant component of the study population. From the population of the community 60 respondents were selected using The multi stage sampling design and systematic sampling. 20 health workers , 10 community leaders and 10 in charges of health units comprised the other part of the study population. The study population therefore, was comprised of 100 respondents

3.3 Methods of Data Collection.

The researcher employed a variety of research instruments strategically selected and commensurate for the analysis of the role of community participation in improving social services to rural communities in Uganda. The choice of the research methods fully considered the abilities of the different categories of stakeholders in the delivery of health service management in the study area. Among the considerations were: the educational background, the responsibilities held (leadership positions), and their roles in service provision or consumption. This was purposely to allow flexibility, easy interpretation of

the issues in question, and to allow quick response. The overall goal of all this effort was to allow the researcher access to as much information, and as much accurate information as possible, from all the respondents with minimum bias if any.

The research methods used were broadly categorized into two: the primary and the secondary methods of data collection.

3.3.1 primary data collection

Questionnaires, interviews and Focused Group Discussions were among the primary methods of data collection used in this study. Focused group discussions were used to get information from the community members, who are the intended beneficiaries of the health services delivered in decentralized frame work. Six focused group discussions were formed to ensure that the required information is got from the community.

The use of the questionnaires and structured interview methods, was for purposes of analyzing different view points of different respondents on the same issue, to increase the validity and objectivity of the research results.

The researcher carefully designed questionnaires for collecting data in accordance to the specification in the research problems, the hypothesis and the objectives of the study.

Some questionnaires were home delivered and this allowed the respondents to fill them at their own convenience; while others were personally administered with on-the-sport collection in order to provide quick results. The interviews permitted the researcher to follow-up and thus obtain more data on the research problem. The interviews further enabled the researcher to judge the sincerely, frankness, truthfulness and insights of the interviewees' responses through cross examination. To some respondents, more than one research instrument was used; for instance questionnaires and structured interviews were applied to the health unit in-charges, the staff at the Health units and some community leaders, especially the local council three (LC3) and LC IV leadership. To the rest of the

community, the research instrument applied was predominately the structured interview and none-structured interviews.

3.3.2 Secondary data collection methods

The researcher, viewed related literature from the studies of other academicians, textbooks, published reports and statements, minutes of meetings, health information system data bases and support supervision reports, encyclopedias, dictionaries and journals. The review of literature, required a lot of time and effort to identify, locate and analyze existing documents and information on the study subject, with the objective of revealing contributions, weaknesses and gaps.

3.4 Sampling.

This area was concerned with establishment of the sampling procedure, the population of study and determination of the sample size.

3.4.1 Sampling Procedure.

The researcher used both simple random sampling and stratified sampling procedures This was to ensure, that there was a proportional representation of the population sub-groups, that is; the different cadres of health workers; involvement of both male and female respondents from the community members; in-charges for the different levels of health units, for instance, health centers II, III, IV and the hospital; and community leaders for the various local councils I, II, III and IV.

Health unit in-charges and community leaders, were selected purposively. In this type of selection, the researcher used his own judgment and common sense, regarding the respondents, from whom information was to be collected. The researcher, selected health unit in-charges and community leaders purposively because, the researcher had in his mind, that these respondents had the information he required. The researcher believed the

health unit in-charges knew what was going on in their Health units; and that the community leaders knew what was going on in the county/health sub district.

On the other side, the random involvement of the staff at the Health units and the members of the community, was to allow the researcher to understand the functioning of the health service delivering system and how it was impacting on the livelihoods of the indigenous population. The researcher, therefore, saw it necessary to supplement leadership discussions with lower health unit staff and ordinary men and women from the community who were believed to have important information regarding the research problem.

The researcher, first established the number of villages in the HSD(80), then 4 villages were sampled by simple random design due to financial limitations. LC lists of the residents from the villages were then used to pick the house holds from were the responds were picked. Focused group discussions was the most appropriate research method applied here. we were ,however, mindful of including both male and female responds in our study. Of the 4 villages picked we were also mindful to purposively pick , one seemingly less rural village comparative to others , so that, a more representative results are got. A total of 15 respondents were picked from each of the four house holds. 20 health workers were used in the sample study, picked purposively by cadre , then by simple random sampling. Then 10 In charges of health units and 10 community leaders of the various levels were purposively employed in the research study.

3.4.2 Determination of Sample Size

Since the research was largely qualitative and involved an intensive interaction with individuals in order to meet the objectives of the research study, the researcher found it reasonable to use a relatively small number of 100 respondents. The researcher, however, did not determine the sample size in advance. The determination of the sample size

depended on the researchers' judgment on whether the data for the different sub-groups that is the health workers, the community members and the health unit in charges would be analyzed; also considered in determining the sample size, was the population of the research area.

To ensure that the research was completed within the limited time available, the researcher used only 100 respondents but studied in-depth the different range of units understudy. Considering the above effort and deliberations applied, the researcher therefore used the rule of thumb approach,(Martin,2005) in determining the sample size.

3.5 Data Processing, Analysis and Presentation

Data was analyzed manually, with the help of computer programme; micro soft excel. The data is presented in tables, graphs and pie-charts

3.6 Ethical Considerations

The study was carried out with permission and full knowledge of the in-charge Butambala health sub district ,in charges of the health units and the local government community leaders. No respondents name was mentioned in this research report.

There was need for the researcher to use professional and ethical standards to plan, collect and process data. The researcher ensured that he was objective and used objective methods in data collection. The researcher made sure that any element of individual bias was subdued in favour of well-accepted systematic and objective measures.

The methodology chosen for the research was selected on the basis of the research objectives and not for other reasons. The researcher, ensured that he recognizes the boundaries of his competence in selection of methodology, and the researcher, also made sure that he uses only those techniques for which he was qualified by education, training

and experience. Whenever in doubt, the researcher sought clarification from the research community especially the immediate supervisor and research colleagues.

The researcher, also ensured that data was interpreted according to general methodological standards and not in line with the researcher's fancy. The researcher, made sure that elements which were irrelevant to data interpretation were excluded from the report. The researcher, ensured that he reports accurately what he found out in the study, properly explaining the methods used and reasons for doing so.

The researcher, made sure that he collected data according to accepted research standards, ensuring that he does not mislead those who will read the research report.

The researcher kept all the information given to him very confidential and used it only for purposes indicated as the justification of the study.

3.7 Dissemination of findings

The findings are to be discussed with all community leaders, all health unit in charges, the health workers and community members. This will be done in two separate meetings; one at the health sub district for the health personnel; and the other, at the sub county head quarters, for the community leaders and members of the general community.

3.8 Project management

Two research assistants were identified and trained on the use of questionnaires and the structured interview guide. The training of the research assistants took one day. This was followed by pre-testing of the questionnaire with 10 health workers. Findings from the pre-testing exercise were discussed and adjustments made. Together with the principal researcher, and the two research assistants, a team of three was made who collected data together. The data collected was cross checked in the presence of all the three members, before it was finally entered. This approach was made to ensure quality control.

3.9.1 Limitations of the Study

One of the major limitations anticipated was, failure to raise to meet al the intended respondents, which could compromise the validity of the findings. This was however, minimized by inviting in-charges of health units and community leaders in a series of sensitization meetings for each group, and fixing dates with them. These appointment dates were strictly adhered to. In relation to this, all health unit in charges and community leaders with telephones, were requested to avail us their telephone numbers to allow us keep in touch, whenever there was need to do so. Carrying out a research in the entire health sub district required substantial financial resources. The researcher, however, endeavored to work within the stipulated time frame and the available financial resources.

CHAPTER FOUR

FINDINGS, DATA PRESENTATION AND INTERPRETATION

4. 0 Introduction

The analysis, interpretation and presentation of the findings were classified according to the objectives of the research study. The presentation of data was done using both qualitative and quantitative research methods. Data analysis was done using the Micro Soft Excel.. Quantitative presentation of data involved the quantification of respondents on various issues, while the different perspectives of the respondents were presented qualitatively. The researcher's intention for such a presentation was to clearly find out, and show how decentralized health service management impact on the livelihoods of rural communities.

4.1 The Effect of Management Structures on Community Participation

Information on this subject was classified in four categories: the knowledge of the community about the existing management structures; the manner in which these structures are formed; the functions of the management committees; and the frequency of holding meetings by the various committees. This was all intended to clearly bring out how these structures created under decentralization impact on community participation.

4.1.1 Level of Community Awareness about Established Management Structures in the HSD

The intention of assessing the level of community awareness of the existing management structures was based on the argument raised in the literature review according to Broeck and Berlage (2001); that "quality information is a right and a tool for development". The more people are informed, the more they will participate.

Table 4. 1: Showing the frequency of responses on the established management structures.

RESPONSE	FREQUENCY	PERCENTAGE
Yes	45	45%
Not sure	30	30%
No	25	25%
Total	100	100%

Source: field survey report 2006

Findings from the table(4.1), above indicate that; of the 100 respondents asked whether there are established management structures in the HSD, 45(45%), said, they were aware, while, 30(30%) were not sure of the available management structures, 25(25%) said; that there are no structures.

The above findings, imply that a large proportion of the community is not aware of the existing management structures; it further indicates that there is an information gap between management and the community. Community participation is grossly weakened as a result of poor flow of information.

According to the research findings, few people are aware of the structure of the health care system. It is therefore possible that the community is not informed where and who provides which services. The intended beneficiaries of this development strategy therefore, do not fully benefit. Therefore, the notion, that, Equity requires that services should be accessible to everyone, paying particular attention to the typical rural communities and vulnerable groups, is largely not achieved.

The researcher, was also interested in finding out what type of management structures, where well known to the community. The major purpose of this was, to find out the

placement of such structures in relation to the communities. Whether they were from within the communities or from out side the vicinity of the intended beneficiaries; and then assess how these structures impact on community participation.

Table 4. 2: Showing mentioned structures known by the respondents

RESPONSE	FREQUENCY	PERCENTAGE
District Health community	50	50%
Health Sub districts	20	20%
District Health team	30	30%
Total	**100**	**100%**

Source: field survey report 2006

The information got from the table(4.2), indicates that; of the 100 respondents, 50(50%), pointed out that the management structure they knew was, the district health committee, 20(20%), mentioned the health sub district (HSD) as the structure they knew, while, 30(30%) of the respondents mentioned the district health team as the available structure they know. The researcher actually found out that some community members were not even aware of the presence of any health management committees.

The researcher's view on the findings is that, most management structures, known to the community are high level management structures; despite the fact that the HSD progressive reports (2005), indicate the presence of lower management structures like: the health unit management committees, the village health committees, the sub county management committees and the parish health committees.

It also implies that the higher level management committees, like the district health committee, the health sub district core team and the district health team reflected in the findings above, have considerable power, compared to the lower level management structures.

The sub county committees, the parish and village health committees comprise mostly of the people coming from, and residing in these villages (HSD progressive reports 2004), such committees would therefore understand community problems better than the higher level structures, and hence they would suggest more realistic solutions to community health problems and in return the livelihoods of the rural population would be improved. These lower level health management structures are therefore, ideal mechanisms for effective community participation in decision making. However, the information given above also suggests that these committees are organizationally weak.

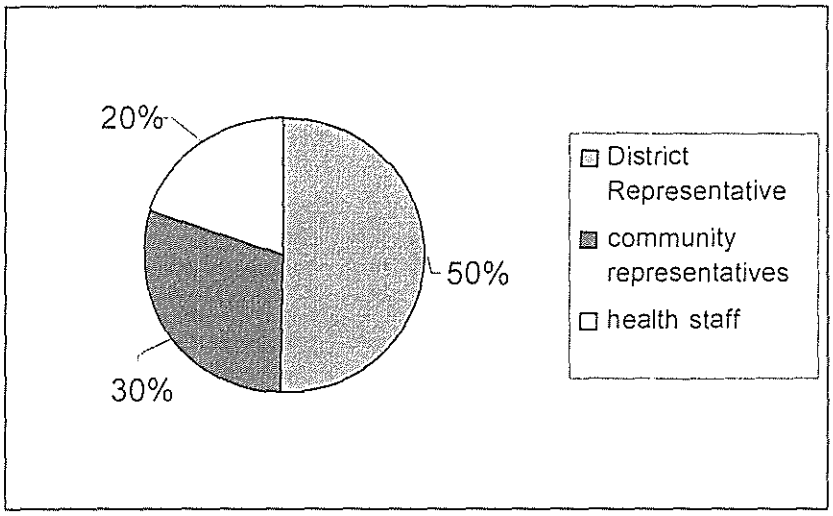
4.1.2. Composition of the Management Structures

The researcher, found it necessary to find out the composition of the management structures, to assess the extent to which community participation is promoted in these structures.

The health unit management committee (HUMC), was seen as the most ideal for this purpose because, the literature according to (Inke, 2000; Saito 2002), had indicated that, this committee comprises of various stakeholders of health management at the health sub district. It was reported as the most significant committee as much as the management of health units are concerned. The health sub district progressive reports (2004), placed the HUMC as one of the lower level management structures, whose membership is appointed by the sub county executive committee and seconded by the council. The functions of the HUMC ,according to the HSD progressive reports (2004), were; participation in the

health planning, monitoring, implementation of health programmes by the health units, ensure the proper use of drugs, and to address community complaints.

Chart 4 : Showing the composition of the HUMC



Source: HSD Progressive reports 2004/05

The information from the findings in chart 3 above, shows that district representatives are the majority of the committee members since they constitute 50% of the members; community representatives constitute 30%, while the health staff at the health units,constitute 20% of the HUMC membership.

According to the researcher, the implication of these findings is that the district authorities have over dominated the planning activities of the health unit management

committees. This kind of representation in the researcher's view limits community participation in the management of health services.

4.1.3. HUMC Meetings as an Avenue for Interaction with the Community

The researcher, was interested in finding out, how effectively the HUMC communicates with the community on health issues and how it addresses the issues that arise there from. The main communication avenue got from the HSD progressive reports was through meetings.

Since the HUMC was seen as a link between the community and the health units, the researcher, focused on getting information about management meetings from the health unit reports, HSD reports, the Health unit staff, the community leaders and the community members.

The HSD and the Health Unit reports (2004/2005), indicated that HUMC meetings are held monthly. The information got from the health unit staff was similar to that got from the HSD/Health unit progressive reports. However, the information from the community leaders, showed a big variation from that of the reports and the health unit staff. The community leaders showed dissatisfaction about the performance of the HUMC(s), which they accused of not holding regular meetings concerning the health situation in the HSD.

Information got from the community members about HUMC meetings, was as portrayed in the table below

Table 4. 3: Showing the frequency of holding meetings by the HUMC

Response	Frequency	Percentage
No	50	50%
Not sure	50	50%
Total	**100**	**100%**

Source: Field survey Report (2006).

The information got from the response from community members as indicated in table(4.3) above, was in line with the issues raised by the community leaders. Of the 100 respondents interviewed, 50(50%) said that there are no such meetings, 50(50%) said that they are not aware that such meetings existed at all. The information from the findings implies that, even when meetings are held, the community is not informed of the outcome.

There is also a tendency for these committees to reproduce existing power relations. In short, the linkage between these committees with the community is weak. Consequently, this does not promote participative planning.

Participation is further weakened as a result of poor flow of information. Because of the weak linkage between the lower management committees and the community, few people are aware of the structures of the health care system. While vital information is generated from people, the use of that information is often limited. Feedback mechanisms are weak.

Information from Focused Group Discussions indicates that, week feed back mechanisms, creates an information gap. This is a hindrance to community participation in the management of health programmes and hence a hindrance to rural development.

4.1.4 Involvement of the Village Health Management Committee (VHC), in the Development of Health Plans.

According to the reports, the researcher found it necessary to get information about the level of involvement of the Village health committee, in the health planning process. The choice of the VHC was based on the fact that it was the lowest committee as reflected in the chart on the health delivery system in chapter II of this study. The researcher, acknowledges that planning is necessary if effective health service delivery is to be achieved in rural areas. Without knowing where we are going, it is unlikely that we will get there. He sees planning as the road map. It focuses the attention of health management teams, health personnel and community members, and helps determine where the community is going. This is the very reason why the researcher, was concerned with the aspect of community participation in planning because; the community members know their problems better than any other stakeholder and therefore can suggest appropriate solutions for these problems. From the researchers view, the involvement of the community in planning is very instrumental in the attainment of health goals and overall community development.

Table 4. 4: Showing the Involvement of the VHC in development of health plans

RESPONSE	FREQUENCY	PERCENTAGE
Yes	25	25%
No	45	45%
Not sure	30	30%
Total	100	100%

Source: field survey report 2006

From table4.4 above, only 25(25%) of the respondents said, there was involvement of VHC in the development of health plans. Nine (45), that is 45% of the respondents said, there was no involvement of the village VHC in the development of the health plans, while the rest (30%) were not sure.

The findings imply that, whereas planning as a management function is evident in the health unit management committees, the local management committees are inadequately involved yet they represent the large clientele in the provision of services. While we acknowledge that community involvement in health planning is important, the results indicate that their involvement is not felt by the entire community

4.1.5. Involvement of Health Staff in the Health Planning Process

The researcher, recognizing that the health staff play every key role in the delivery of health services, was interested in knowing the extent to which the health staff participate in the development of health plans. The results were as reflected in the table below.

Table 4. 5: Showing the involvement of the health staff in the planning process

RESPONSE	FREQUENCY	PERCENTAGE
Yes	55	55%
No	20	20%
Not Sure	25	25%
Total	100	100%

Source: field survey report 2006

The information in table 4.5 above indicate that 55(55%) of the respondents answered that staffs do participate in development of health plans, 20(20%) said they do not participate in the development of health plans, while 25(25%) were not sure.

According to the information from the respondents, it implies that the health staff at the health units is not fully integrated in the planning process of the health sub district. The researchers' view is that, since the staff are directly in touch with the community at the health units, they would have more realistic solutions to any emerging problems between the health units and the community.

4.1.6. Involving Stakeholders in the Planning Process

The research, revealed that the community saw a number of advantages in their involvement in the planning process. Among the advantages highlighted were; generation of different solutions/ideas; joint monitoring efforts, and ownership of the health plan.

The researcher's view, on wide involvement of the various stakeholders in the health planning process is that, attention to social justice is vital if development is to produce positive results and if society is to develop in a balanced way; this is in line with the literature by Panpile Sabahara (1998).

If on the other side, only views from a small section of the society are considered in these health plans, the majority of the people will remain suffering; in this case, this can not be referred to as community development.

According to Stella M. Sabitti (1998), development and spending priorities need to be broad-based, equitable and inclusive. Such a kind of development can only be achieved when the needs of all social groups in a given community are considered in the planning process. Development must therefore, focus on social justice.

4.1.7. Problems Encountered as a Result of the Planning Process Involving Different Stakeholders

The study revealed, that the involvement of the community, community leaders, community health workers, the health staff, in the planning process is associated with a number of problems; which included; time wasting and many demands against limited resources.

Table 4. 6: Showing problems encountered

Response	Percentage	Cumulative percentage
Time wasting	50%	50%
Many demands	50%	50%
Total	**100%**	**100%**

Source: field survey report 2006

Findings from table 4.6 above, show that (50%), of the respondents mentioned time wasting as the major problem created as a result of several categories of people getting involved in the planning process. The other 50% pointed out that, the problem was, putting many demands against few resources. When asked to suggest ways of solving these problems, the respondents suggested a number of ways that included; sensitization of stakeholders about the planning process, budgeting and formation of representative core planning teams.

The researchers view is that, while it may be true that involvement of various stakeholders in planning can be a time-consuming process initially, it is however, an extremely important one, in that, the more the community is aware of what is involved, the less time it will in the long run take. But if you rush the issues, there will be unrealistic expectations on both the side of the community and the health sib district team, and the programme might be a failure. This argument concurs with the literature according to Dr. Piet Reiter, (1999) in chapter 2 of this research study.

Development must certainly involve people of varying socio-economic status, varying occupations and skill levels, varying levels of ambition, awareness and enlightenment.
The researcher also shares his wisdom with the literature according to Olum, (2000), who remarked that, development in any meaningful sense, must begin with, within, the individual or the individual community. Development is therefore, a process of gradual change, where people increase the awareness of their capabilities and common interests, and use this knowledge to analyze their needs; decide on solutions, organize themselves for co-operative efforts; mobilize their own human, financial and natural resources to improve, establish and maintain their own social services and institutions within the context of their own culture and their own political system. The decentralization of health services in Uganda, to the health sub district level has therefore, to some extent enhanced community participation, though not yet, fully, and therefore, it is highly hopeful that it will impact positively to development of these rural communities in line with objective III of the research study.

4.2 Quality of Services Offered.

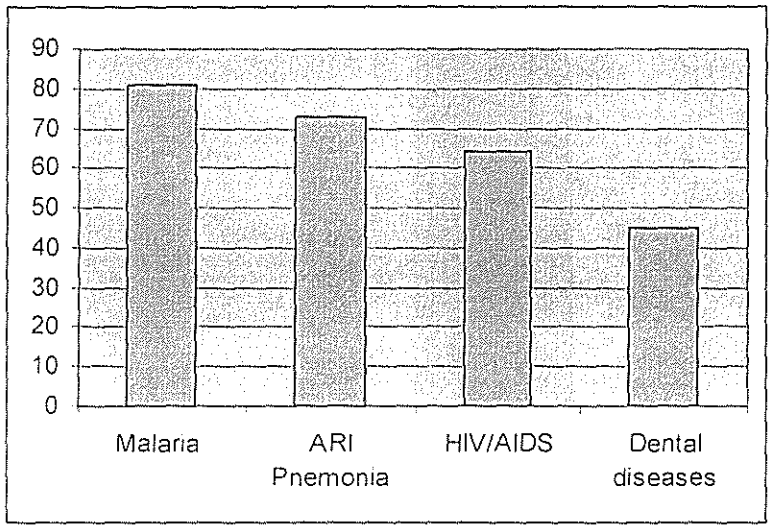
To establish the quality of services offered in the research area, the researcher found it necessary to initially find out the kind of diseases that are predominant in the research area. This information was acquired from, the Health Sub District reports as well as through questionnaires and interviews of the community members, the health workers, the community leaders and the Health unit in-charges. The quality of services was then assessed, according to, accessibility of the population to the services, affordability of the treatment, and availability of the services. The Quality of services delivered was also measured against the key health indicators as portrayed in table 1.1, in chapter one, of this research report..

Diseases with the Highest Rate of Occurrence

The top five diseases in the study area, according to the Health Sub-District reports (2004/2005) included; Malaria, acute respiratory infections, intestinal worms, HIV/AIDS, Anaemia, Pneumonia and dental diseases.

The five diseases with the highest rate of occurrence, as given by the respondents, gave similar cases as reflected in the Health Sub-District progressive reports.

Figure 4. 1: Graph showing different diseases



HSD Progressive reports (2004/05) and Field survey report 2006

Of the 100 respondents, 81% identified malaria as the most common disease, while another 73%, identified ARI Pneumonia, as the most common disease. 64% mentioned HIV/AIDS, and 45% of the respondents, identified dental diseases as the most common - diseases in the study area. The research also observed, that all the mentioned diseases are preventable diseases and therefore community participation would be of vital importance in the control of such diseases.

Classification of services offered

Information from the health sub district progressive reports (2005), and from the respondents indicated that the

health services offered by the health sub district were classified into curative, preventive and promotive services. The quality of each category of service was established according to the accessibility, affordability and community responsiveness and availability of the services.

4.2.1. Preventive Services

The preventive services, investigated by the researcher, were according to the common diseases as established in the research study. Since the researcher had found out that all the diseases listed were preventable, it became necessary to find what preventive services were carried out.

4.2.1.1 Health Education

The researcher, established that health education was 'carried out mostly on prevention of malaria, and HIV/AIDS, because they were considered the most fatal, according to the respondents. When asked, when health education is carried out, the researcher was informed that, it is carried out when the sick and other attendants come to the health units for treatment. When further asked, how those people who do not come to seek treatment from the health units benefit, the response of community leaders and the health workers, was that, out-reach programmes to the villages are carried out where sensitization on health issues like use of mosquito nets, clearing of bushes around areas of residence is done in the bid to prevent diseases like malaria.

When the community leaders were asked about their role in this programme, the response was that, their major role was to mobilize the community members to attend, and then invite the health workers to come and give the health talks.

It was also reported that, during these outreach programmes, there is routine de-worming of children under five years of age, screening and treating of those with mild ailments, and referral of severe cases of sickness, to health units for further management. The researcher, thus, found out that these community outreach programmes are integrated and cover a number of health programmes.

The community response, to health education was welcoming, it was however, noted that the community members were more interested on health education during the out-reach programmes because, according to them, the health staff were more friendly, when working from the villages, yet while in the health units, they were a little harsh and rude to the patients.

This prompted the researcher, to find out about the turn-up of the community members during the community outreach programmes. The response of both the health workers and the community leaders was that, the turn-out is normally huge during outreach programmes. Both health workers and community leaders, however, gave poor facilitation as a major hindrance to this programme. In relation to this, the researcher, found out that community outreach programmes were carried out irregularly, which he attributed to poor funding, and poor staffing at the Health units.

The researcher's view of this observation is that, community response to health services will be good, when the services are brought nearer to the people where they can easily access them. This can be attributed to mainly two factors, according to the researcher, the distance from the community to the area of service delivery, the attitude of the health

workers to the community members, and the affordability of the population to these services. These three factors would create a good response from the mass of the population and it would lead to a health population and eventually overall community development.

4.2.1.2 Immunization

Immunization, was another preventive service offered in the Health sub district, as reflected in the health sub district progressive reports (2004/2005), and from the respondents' views.

Immunization against the "six killer diseases," that is, measles, diphtheria, tetanus, whooping cough, polio and tuberculosis, according to the health workers and community leaders, was one of the most successful preventive measures offered in the health sub district. There was agreement among the respondents that the reduction of measles, a disease that used to formerly kill large numbers of children in this area, was largely attributable to a successful immunization programme.

As a result of this assumed success, the researcher, wanted to find out how this programme was/is organized, and what the cost was for the community members.

The response by the health workers and community leaders, was that the programme mostly succeeded due to massive community sensitization programmes on what immunization was, and how it would impact on the lives of their children. This was done through posters, village meetings, and school health talks. The respondents, further said that different categories of people from within the research area fully participated in this

programme. Mentioned among these were the community leaders, health workers, the village health workers, community volunteers and teachers.

Considering this big stake holder's involvement, the researcher wanted to find out where the programme was carried out.

The response was that immunization is carried out at the health units routinely as the children were brought for treatment for other ailments, community out-reaches to the villages were also carried out on specified days, were immunization was carried out , and in primary schools; pregnant women coming for antenatal care were also immunized.

The researcher, therefore wanted to find out what the cost of each person immunized was. All the respondents unanimously, agreed that immunization was free of charge.

The researcher's view on this is that, the success of a health programme largely relies on massive stakeholder participation. And that once the community fully understands what a health intervention is about, and how it will benefit the community, then the community will willingly participate. High costs of health services, greatly and negatively impact on community responsiveness and this can lead to massive loss of lives of the population and in the long run will become an obstacle to community development' as most of the time that would have been used in development activities, is spent caring for the sick and worse still the potential human resource that could have driven the community to development is lost.

4.2.1.3 Antenatal Care

Antenatal care, is another preventive service offered by the health delivery system in this area. When asked the relevancy of this service to the community, the respondents who were mostly health workers, said it is the routine monitoring given to pregnant mothers so that, they and their babies do not get health problems like; , death of the mother during or after delivery. The researcher, was further interested in the specific kind of activities offered in this care.

The respondents, in response mentioned activities like immunization, health education on diet during pregnancy and danger signs during pregnancy among others.

The researcher, then, interested in the mode of delivery, asked the respondents how the services are finally delivered to the intended community members(the pregnant mothers). The information got from the respondents, was that, antenatal services were mainly health unit based, and that to permit full attention to those mothers, specific days are highlighted to this service, at maximum two days in a week, in special clinics-the Antenantal clinics.

The researcher, interested in finding out the turn-up of mothers at these clinics, asked what the community response towards antenatal care has been.

The information got from the health workers was that, the turn up was not so big, the health workers attributed the low turn-up to traditional beliefs in herbal medicines that are believed to make deliveries safe; and the high levels of poverty among the populace, making it hard for the mothers to contribute the 'small fee' attached to the services offered.

The belief in herbal medication prompted the researcher, to ask whether the health workers have made an effort to health educate or interact and share ideas with these traditional herbalists and traditional birth attendants. The response was that, workshops have been organized where health education about safe deliveries and danger signs during pregnancy is given.

The community members, interviewed on the poor response towards antenatal care however, tended to differ from the views given by the health workers.

Community members had more confidence in the traditional herbalists because, there were according to them, many cases that had delivered safely with the help of herbal medicine, having been earmarked as risky cases by the health staff.

The other reason given by the community members, was that the health workers at times treat them harshly when they go for services at the health units, while the traditional birth attendants were more caring.

Some respondents, sighted the long distances to the health units from the village as a problem. In agreement with the health workers views, some community members looked at the cost of accessing these services as unaffordable to them.

4.2.2 Curative Services

Among the category of services offered by the health sub district according to HSD progressive reports, and according to information from the respondents was the curative services. According to the respondents , such services are exclusively health unit based. The services involve both diagnosis and treatment of the disease conditions found in the research area.

The researcher, assessed the quality of services according to accessibility of the services by the population, affordability of the service by, the community, and availability of drugs for these disease conditions. The quality of service, was measured according to whether particular diseases, were treated according to standard treatment guidelines set by the World Health Organization (WHO) and the Ministry Of Health (MOH) guidelines.

The researcher found out that different categories of respondents had different views on accessibility to these services.

Information from the respondents, was that, the community is more responsive to treatment at health units now than in the past, the main reason given for this increase in turn-up of patients to health units was that, it was because of the health education given during out reach programmes to villages/the community, on the services available at these units, the existing good relationship between the health workers and community leaders was also put as a big factor, causing his positive community response towards services at the health unit.

Table 4. 7: Showing treatment according to guidelines

RESPONSE	FREQUENCY	PERCENTAGE
Yes	35	35%
No	25	25%
Not sure	40	40%
Total	**100**	**100%**

Source: field survey report 2006

When asked about the diagnosis and treatment of STI/HIV/AIDS and malaria according to standard treatment guidelines, 35% of the respondents said that, guidelines are present

and followed during the management of these cases; 40(40%) of the respondents were not sure, and 25% said it is not done.

The researcher, however, noted that most of the respondents who said, that there were no treatment guidelines were from lower level health units that is, health center I and Health center II.

However, during the survey of the health units, the researcher had observed that most health units had posters of these treatment guidelines pinned on the walls in these health units.

The researcher therefore, made a generalization that, lower level health units' staff did not follow the guidelines for treatment of diseases conditions as stipulated by WHO and the MOH. The knowledge gap between the health staff from the various health units also indicated that information flow within the health structure was not uniform. The researcher, therefore, looked at this as a hindrance to quality service provision to the community because, lower health units, are the grass root health units where most of the population dwells and therefore can easily access health services.

On the availability of drugs, almost all respondents agreed that drugs are always available at the health units.

The researcher was then, interested in finding out, how affordable these drugs were to the community members. This raised differing views from the respondents;

The health workers said that issuing of drugs is based on two different criteria. The first criterion was based on the disease condition found out. The other based on the patients ability to pay for the drugs. To this, the patients were classified into Grade B and Grade A patients. Grade B according to the respondents was for those unable to pay, and Grade A, for those with ability to pay.

On further investigation, the researcher however, found that the biggest part of the grass root population was unable to pay for the drugs and as a consequence they could not access all the drugs whenever need arises. To the researcher, he saw a possibility of compromising the quality of services offered in the health sub-district.

At this point, the researcher became interested, in finding out the view of the community members on the cost the drugs. Many of the respondents' views were that they could not afford the cost of the drugs at the health units, while a handful of them, said the drugs were relatively cheaper compared to the cost in the private health settings.

Since most of the community members according to the research findings could not afford the cost of the drugs, the researcher, was further interested in finding out how these community members treat the disease conditions. The findings were that, some resort to use of traditional herbs, while others stay and leave their fate to God.

To the researcher this implies that the quality of services in the health sub-district is compromised. This is so because, the research findings indicate to the fact that most deaths are as a result of simple ailments, that could otherwise be cured with simple treatment. Such deaths, in the researcher's view, lead to loss of the would be useful human resource for the development of the rural community.

4.2.3 Promotive Services

The information got from the health sub district progressive reports (2004/2005), and from the respondents, showed that promotive services was another category of health services offered in this Health-sub district. When the researcher asked the respondents what promotive services are; the information given was that they are services aimed at developing good health behaviour in the community. Among the activities highlighted in this category of services, from the health sub-district reports 2004/2005 were; promotion and provision of condoms, promotion of good nutrition, provision of safe water , family planning and proper disposal of wastes.

Based on the Key health indicators of the health sub district(table 1.1), that showed the maternal mortality rate at 506/1000 (the health sub-district progressive Reports 2005) and on the findings that STI/HIV Aids were among the commonest diseases in the research area, the researcher was interested in finding out about family planning services and the promotion and provision of condom use, since health reports indicated that, it is one of the measures for preventing HIV/ AIDS and STIs.

The researcher, aware of the importance of nutrition in body defense against diseases from various literature, also found it necessary to investigate the promotion of good nutrition.

The quality of promotive services in this research study, was therefore assessed according to the availability of family planning services and condoms; the accessibility of these services; and the affordability of the services. The health indicators as reflected in appendix 1 are a measure of performance some of some of the services given.

4.2.3.1. **Family Planning Services**

The researcher, was also interested in family planning services because inappropriate timing and spacing of pregnancies and excessive numbers of pregnancies were sighted as the factors responsible for maternal deaths, infant mortality, and serious morbidity among women and their children (E.Tarimo, 1996).

The findings, indicate that, different categories of respondents had various views about the availability and accessibility of family planning methods. The research findings revealed that; of the 100 respondents ,45(45%) of them indicated that the health sub district provides family planning services, 25(25%), were not sure of the presence of these services, while 30(30%), said these services were not actually available.

Table 4. 8: Showing Provision of family planning services

RESPONSE	FREQUENCY	PERCENTAGE
Use	25	25%
Do not use	75	75%
Total	100	100%

Source: field survey report 2006

The researcher was further, interested in finding out whether these family planning services or methods are used by the community. To this effect, of all the respondents who were aware of the presence or provision of these services, only 25(25%) accepted usage of family planning methods, while 75(75%), said they do not use family planning methods.

The researcher had to further investigate why family planning services were not used by most people in the community. Most of the respondents attributed non-usage of family

planning services to side effects that were undesirable. One of which was "bearing of children with missing parts of the body".

When the researcher, however, sought information from the health professionals, the response attributed non compliance, to the use of family planning services, to strong traditional beliefs and the high level of ignorance within community members.

4.2.3.2 Promotion of Good Nutrition

The HSD health reports, indicated that, nutrition plays a big role in boosting the immune system of people. The researcher, therefore, found it necessary to investigate the extent to which nutrition promotion is done in the research area. The researcher assessed the quality of this service by; level of community participation in this service and the extent to which the community is complying.

The researcher, was initially interested in finding out, whether the community members are aware of this service in the HSD. The findings were as in Table (4.10) below

Table 4. 9: Showing awareness of the community of nutrition promotion services

RESPONSE	FREQUENCY	PERCENTAGE
Yes	50	50%
Not sure	30	30%
No	20	20%
Total	100	100

Source: field survey report 2006

Of the 100 respondents, 50(50%) of them accepted that there is promotion of good nutrition in the health sub district 30(30%) of the respondents said they were not sure,

while 20(20%), disagreed to the statement that such a service did exist in the health sub district.

This propagated the researcher to investigate the strategies of delivery of management of the service. .

The strategies used by the health workers were mostly health Unit based, and this included health education, which according to this category of respondents was integrated in specific clinics, like the children's clinic and the immunization clinics. Special nutrition clinics are also set up at the health units for demonstration purposes. In these clinics mothers especially, are practically encouraged to participate in preparations of nutritious foods for their children.

In the bid to reach a large of population of the research area, sensitization of the community on proper nutrition is integrated in community out reach programmes where again demonstrations are carried out. The researcher was therefore interested in finding out the role of community members in this programme.

The information got from the respondents was that two volunteers are got from each village and trained. These then take care of community demonstration gardens; they are also in charge of routine community sensitization. To the researcher, the quality of this service is enhanced by the level of community participation.

4.2.3.3 Promotion and Provision of Condom use to Prevent STI/HIV/AIDS

The listing of HIV/AIDS and STIs among the common diseases in the HSD motivated the researcher to carry out an investigation on the promotion and provision of condom use in the research area.

The quality of this service according to the researcher, was measured against indicators such as: availability of the condoms; community acceptability, reflected in terms of usage; and the affordability. The researcher was initially interested to find out the level of community awareness about the existence of this service. Most of the respondents in this aspect where community members. The results were as in table 15 below.

Table 4. 10: Showing the Level of community awareness of the promotion and provision of condoms.

RESPONSE	FREQUENCY	PERCENTAGE
Yes	45	45%
Not sure	30	30%
No	25	25%
Total	100	100%

Source: field survey report 2006

When asked whether the health units provide condoms, the results were as shown in table(4.11)above, 45(45%) of the respondents said there is promotion and provision of condoms ,30(30%) of the respondents were not sure, while 25(25%) said there is no promotion of condom use.

To find out whether these condoms were affordable, the researcher asked the respondents how much they paid to access this service. All respondents, said that, these condoms were provided free of charge.

The health workers however, attributed the low level usage of these condoms to societal stigma about the use of condoms. The view of the researcher is that there exists an information gap about the importance of these condoms in the prevention of STI and HIV/AIDS. There is therefore a necessity to intensify community sensitization about the importance of these services, most especially considering the severe damage, that can be caused to the community as a result of infection with HIV/AIDS and other STIs, and how profoundly this hinders community development.

4.3 Community Involvement

It is widely believed that, decentralization increases popular participation in decision making, because it brings government closer to people and makes it more accessible and responsive to peoples' needs, (Uganda participatory poverty assessment II 2002). The researcher was therefore interested to find out how community participation in health care affects rural livelihoods.

The researcher, was further interested in getting information about the role of the community in decision making and planning.

The information got from the level of community involvement is as in table 4.12 below

Table 4. 11: Showing the level of community involvement in service provision

RESPONSE	FREQUENCY	PERCENTAGE
Yes	50	50%
Not sure	30	30%
No	20	20%
Total	100	100%

Source: field survey report 2006

The information from the respondents in the table(4.12) above, reveals that, 50(50%) of the respondents are involved in the provision of health services, while 30(30%) were not sure and ,20(20%) of the respondents said, they are not involved.

On further inquiry of the kind of services, in which the community members were involved a range of activities were highlighted by the health workers, the community leaders and the community members.

Table 4. 12: Showing the roles of the community in service provision

Stakeholders	Activities
Community leaders	- community mobilization - monitoring of health services Allocation of funds for community programmes
Community members	- labour - community volunteers in mobilization of other community members - provision of raw materials locally available - construction of feeder roads - funding of community programmes

Source: field survey report 2006

The information in the table(4.13) above, indicates that community members and the community leaders play a number of roles in the provision of health services in the health sub-district.

Among the roles played by the community members, the respondents mentioned the provision of labour, especially during programmes like protection of wells, and spring water in a bid to have clean and safe water, provision of raw materials for instance sand, bricks and stones which are locally available; construction of feeder roads which have increased the accessibility of the population to health services.

When the health workers were asked on the impact of this community involvement, they were in agreement that the community had greatly helped in the provision of these health services, especially basing on the fact that health programmes were greatly under funded in this health sub district and due to the fact the community sensitization was of vital importance.

When the community leaders were asked, how they manage to sustain community initiated activities, the response was that village committees, comprising of 5 (five) people, who are chosen by the community members, are put in charge of routine maintenance of such projects. That community members also subscribe willingly a fee of 50/= (fifty Uganda shillings), for instance per "Jerrican" of water fetched, this goes on the maintenance fund for such projects. In comparison, the community leaders said that the boreholes that had been implanted in the health sub-district by initiatives from RUWASA had long collapsed living the only safe water provision source in the rural areas to the protected springs and wells.

The role of community leaders in the provision of health services was said to be; mobilization of community members towards health programmes for example, immunization, protection of wells and spring water protection.

They attributed the big success of the immunization programme (as reflected in the health indicators of the HSD), to the mobilization efforts of the community leaders. Another

input of community leaders in health service provision according to the information from the respondents was that of monitoring health programmes, for instance, the provision of drugs and to ensure that health workers do their work.

In view of the information got from the respondents, and in relation to the table showing the key health indicators in the health sub district, the researcher noted that the relatively high immunization courage of 72% and safe water coverage of 50% in Butambala HSD ,was largely due to massive community mobilization, that led to high levels of community participation. Therefore, basing on these findings, the researcher re-affirmed, that community participation impacted positively on health service delivery and at the end leads to improvement in rural livelihoods, as was set-out in the specific objective (III) of the research study.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.0 Introduction

The Summary, recommendations and conclusions are based on the findings of the research study.

The recommendations, presentation is structured in line with the objectives of the research study.

The recommendations are addressed to the various stake holders in the health service delivery system.

5.1 Summary of Findings

This section highlights the major findings in the research study. The findings imply that, most of the community members are not aware of the established health management structures. This creates an information gap and therefore, it greatly hinders community participation in health service management and delivery. The composition of the management structures, is largely dominated by the elites, who in most cases stay outside the areas of service implementation, and may not precisely understand, the real community needs.

The weak linkage between the lower health management structures and the community further weakens community participation. This therefore, greatly deprives the community of its role, for instance, monitoring of the health services among other expected community roles, in an ideal decentralized health management framework.

The advantages of community involvement in health service management include among others; the generation of different ideas and solutions towards community health problems, the community develops confidence in the health services provided because; there is a sense of ownership of the service. A management structure that ensures

multiple stakeholder participation therefore, promotes the spirit of social justice and equitable distribution of health services.

A number of problems are however associated with the involvement of many people in the planning process; that is, time wasting and in most cases many demands are placed against limited resources. This can however, be overcome by sensitization of stakeholders. It is believed that, the more the community becomes aware, the less time consuming the process will become and the more sustainable such a process will be.
Findings also revealed that the quality of services is higher in preventive and promotive services, due to the fact that the mode of delivery takes them nearer the people through community out- reach programmmes, compared to the curative services, that are largely health unit based, which limits accessibility to these services. Services with a fee attached, also tend to limit community accessibility. The findings also indicate that, the bad attitude of the health personnel, towards the patients creates poor responsiveness of the community to health services, hence also affecting the quality of services in the health sub district.

5.2 Recommendations

The recommendations raised target, the policy makers, community leaders, health workers and the community members. Overall the major aim of all these recommendations is to create a healthy delivery system that promotes citizen participation which will lead to rural community development.

5.3 Building Structures that Promote Democratic Participation

It is generally agreed, that promoting democracy at the local level holds the key to improving healthy service management and in successfully undertaking the multiple initiatives that fall under the general rubric of development.

Following the findings, that previous centrally driven interventions have not led to improvement in the lives of the ordinary citizens, The policy makers should direct more attention, to developing management structures that promote citizen participation, efficiency, transparency and accountability at the local levels.

The local level Health Management structures like:- The village Management Committees, The Health Unit Management Committees, The Sub-County Management Committees and the Parish Health Management Committees, should be empowered, such that they give people at the grass roots, sufficient organization to participate in public affairs and the matters that affect them directly.

These local level structures should be enabled, to have more control over resources, for example: financial resources and other decisions, that affect them, such that people's freedom of choice and action is expanded.

Basing on the findings of the study, the researcher, therefore, finds it important to address the structural weaknesses through mechanisms such as: restructuring the composition of local level management structures, and having regular village meetings.

5.3.1 Restructuring the Composition of Lower level Management Structures.

The policy makers should ensure that there is a fair proportional representation of the various stake holders in local level management structures. These structures should be formed with strong considerations of the intended beneficiaries of these programmes (the community). This is for the reason that the implementations of these programmes will largely depend on the decisions taken in these management meetings. The composition of such structures should therefore be in such a way that; community representatives representing a population of 89,755 occupy the largest percentage of these committees;

then staff representatives follow representing a population of 150 and lastly the District representatives. This will ensure that, there is fair representation in terms of the constituencies each category of people represents.

The idea is that there is a necessary connection between democracy and development. If "democracy" is defined as the method of rule that allows citizens significant say, directly or through representation; in the manner in which they are governed, and if development is understood at material and qualitative improvement in people's livelihoods; then citizens' participation in decision making must be fostered to give effect to democracy at the local level.

5.3.2 Community Meetings.

The Researcher, aware that the limited level of peoples' participation at the lower local levels ,s a major challenge to the current people participation framework;

Recommendations that, community leaders should regularly convene village meetings, while demonstrating high capacities to mobilize residents, focus meetings, organize appropriate meeting venues accessible to the residents; target major social actors and ensure proper documentation of meeting proceedings.

This will provide a platform for all adult residents to reflect upon issues affecting their communities and decide on village priorities through a deliberative process of visioning.

The major purpose of these meetings should be to produce a vision among all village residents about the kind of future they would like to create.

5.4 Improvement of the Quality of Health Services:

The recommendations on the improvement of the quality of the health services are aimed at improving the accessibility and affordability to the health services.

These recommendations are mostly addressed to the health workers, health units' in-charges, the community leaders, policy makers and community members.

5.4.1 Diversification of the Community Out-reach Programmes:

This is to ensure that services are delivered nearer the community that needs them. Out-reach programmes should not be limited to only promotive and preventive services, but they should also cover the treatment of the common diseases identified in the community(curative services).

The out-come of this diversification is that community members who could not travel long distances to the health units, will now easily access treatment within the communities. These out-reach programmes should further be strengthened by setting up village treatment posts controlled by village health workers or community health volunteers trained in skills for basic health care and referral mechanisms.

5.4.2 Payment for Health Care Services:

To the extent possible, free treatment in government health facilities should be ensured, such that there is universal coverage of the population with basic health care. In recognition of the contribution of private health care workers, to the provisions of health services to the communities, the government should provide some assistances in terms of

funds or drugs to the private health units., and monitor their charges such that the fee charges are affordable to most of the community.

The community should as well, establish strong monitoring mechanisms, to ensure that there are no informal fees charged to the patients, in order to enable the local community benefit from decentralized health services.

In order to deepen health service delivery at grass root level, where it is much needed, there must be a system of incentives, to motivate community health workers and the health personnel to carry out community health programmes.

5.5 Enhancing Community Participation

To be effective, the health sector needs to get maximum participation of the community and individuals in creating and maintaining a healthy environment; maintaining and sustaining preventive and promotive values, sharing with professionals planning, organizing and implementing health programmes; and managing health units.

Equity requires that services should be physically, socially, and financially accessible to every one paying particular attention to the poor and vulnerable groups. The following mechanisms could therefore be adopted to maximize community participation in health care.

5.5.1 Continued Awareness Creation and Orientations:

Learning should be taken as key strategy in community controlled services delivery and it should be a continuous process.

The Health sub-district should therefore, invest a lot in training, research and information sharing.

Before participation is enhanced, the community will need to understand what, why and how to participate. The community members, community leaders and health workers will

continuously need to know their responsibilities and should all have the basic skills to deliver and monitor health service delivery in a decentralized set-up. The learning will become more sustainable and effective when cadres of members within the community are trained as trainers to help in continued information sharing in the communities.

5.5.2 Harmonization and Integration

The principle of Harmonization needs to be taken to greater heights. The efforts of different players in the health sector and other related services need recognition and co-ordination. The skills of these players and their relevant technologies need to be tapped. Partnerships and networks need to be initiated and promoted so as to avoid duplication of services, over concentration of few health activities, and also to take advantage of huge memberships associated with partnership and net works. This process requires the consent of donors, government, private and NGO players without which it would be difficult for decentralized health service delivery to succeed.

5.5.3 Leadership Development.

The process of institutionalizing Health service delivery at the community level will take a longer time and more effort. This process necessitates group leadership development. The District/HSD should invest its effort in training group leaders in skills management and leadership skills. The responsibility of this leadership is to give guidance, mobilize and organize community members, and generally ensure alignment to the ultimate aim of the service.

5.5.4 Continued Community Mobilization.

Mobilizing the community for self-reliance as envisaged by the Health sub District mission needs the immobilizers to move a step further to ensure continued self mobilization. The self mobilization ensures that community members are confident,

independently make decisions either as individuals or within the context of collective group to which each members has voluntarily allied himself/herself.

Extra efforts to ensure that women, youth and disabled persons participate should be devised. This will improve the relevance, efficiency and effectiveness of health interventions.

5.6 Conclusion

The perception is that decentralization is the best interests health service delivery to the grass root people is widely held in the development literature. So strong is this view that literature does not question whether there is social welfare and equity, but concentrates on its implementation mechanisms.

The current decentralization management structures are necessary for creating avenues for local accountability and participation. They are however insufficient to ensure that the desired quality accountability and participation are achieved.

In spite of its good intentions however, Uganda's decentralization process also experiences problems with respect to using decentralization as a health service delivery strategy. Among other things, the extent to which local citizens are involved in decision making and implementation, including monitoring and evaluation of health programs and projects, is less than optimal in many areas of the Health sub district.

There is pre-occupation with top down participative planning and decision making but less emphasis on the actual foundation and fulcrum of local accountability and citizen

participation, organized and informed civil society able to collect and articulate the views from the local communities.

Further more, challenges remain respectively with regard to the capacity of the community structures in important functional areas such as planning, budgeting, supervision, monitoring and evaluation of health programmes. Co-ordination of the various levels of management also poses significances challenges to the local government and capacity must be built further in those areas as well.

5.7 Self Evaluation and Gaps for Future Research

This research being the first of the kind in the health sub district in the recent past has tried to shade light on the extent to which decentralization impacts on the development of rural communities. The study has however, not gone in the details of knowing how the level of education of the community members, impacts on community participation and overall community development. It looked at community participation therefore, not giving an explicit picture of personal educational levels.

So, another study trying to explore more on individual education levels of the community members, can give a clearer picture on this.

Generally, this study has identified the strengths and weaknesses of the decentralized health delivery system, which can be used as a stepping stone to improve the delivery of health services and overall community development.

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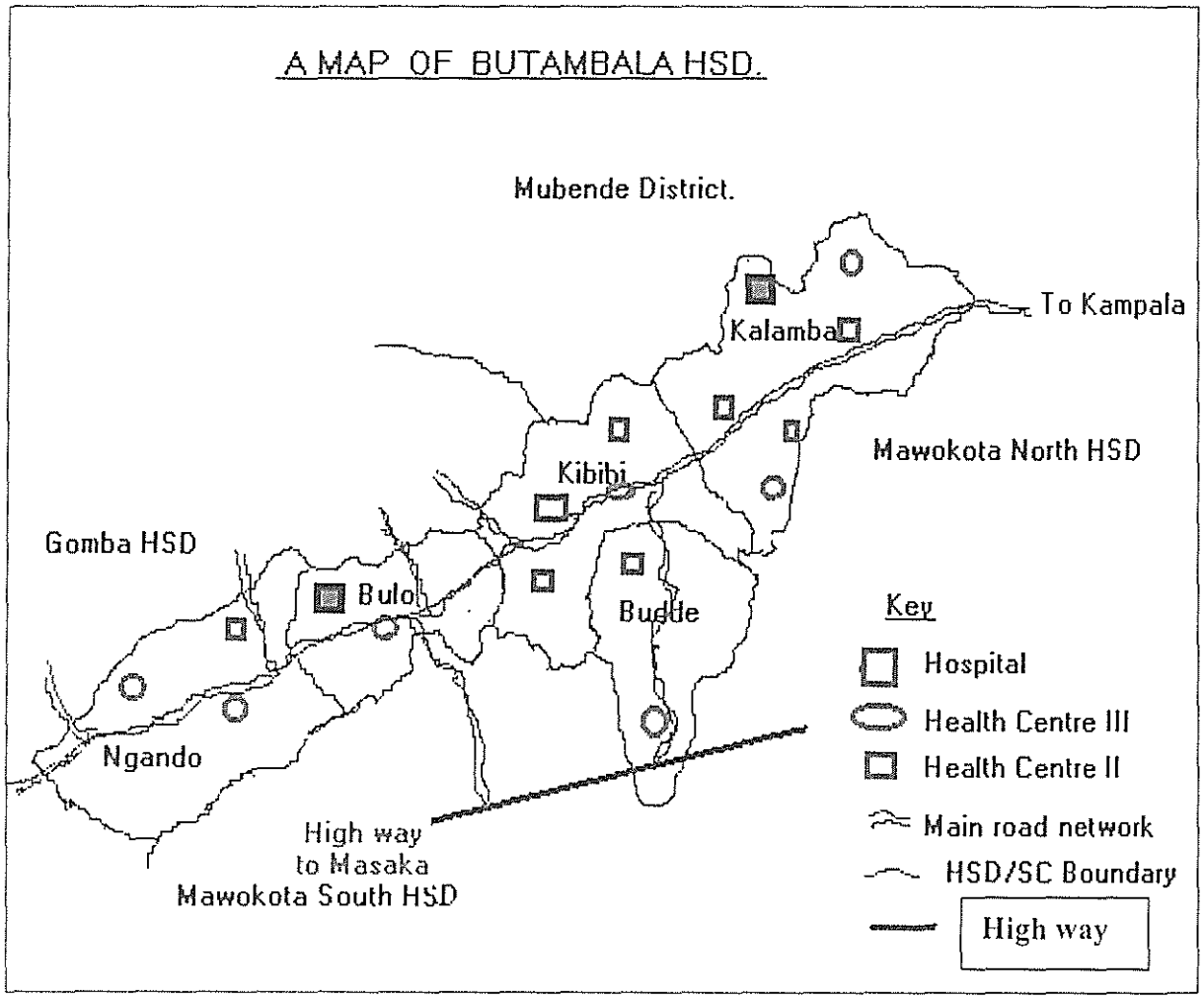
APPENDICES

Annex1

Map of study area



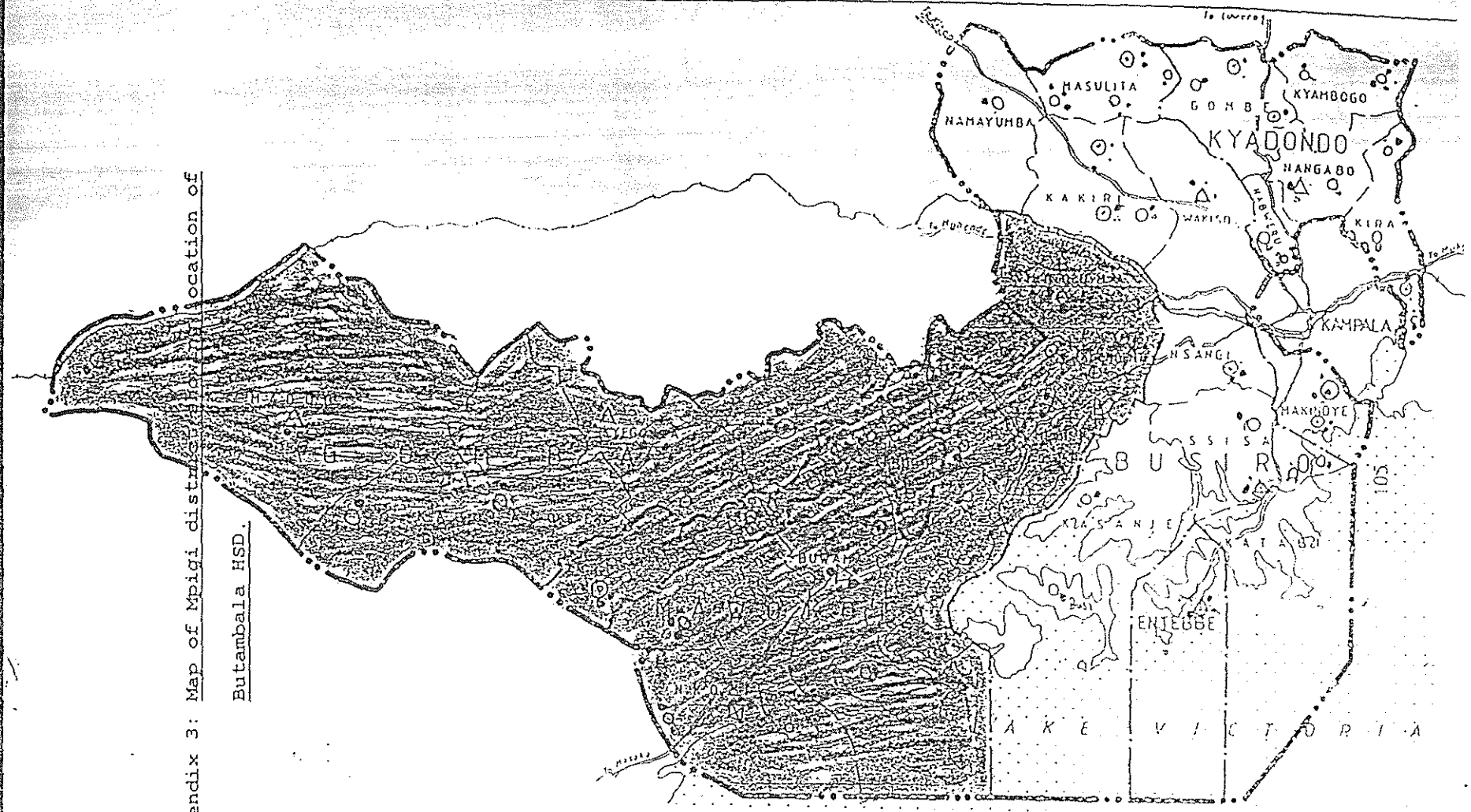
NB: Map not drawn on scale.

BUTAMBALA HSD:

Total population: 87,958.
5 Sub-counties. 1. Budde- 4 Parishes
2. Bulo - 5 Parishes
3. Kalamba- 5 Parishes
4. Kibibi- 7 Parishes
5. Ngando- 4 Parishes
Number of households: 17,742

MPIGI

Appendix 3: Map of Mpigi district showing location of Butambala HSD.



LEGEND

- DISTRICT BOUNDARY
- COUNTY BOUNDARY
- SUB-COUNTY BOUNDARY
- MAIN ROAD
- MINOR ROAD

⊕ Hosp.
△ HC
⊙ DMO

- FP
- ANC
- Maternity
- STD

FP 59
ANC 45

TOTAL=87
RA = 67

CENSUS OFFICE
STATISTICS DEPARTMENT

Butamabala Health Sub-District
C/o Gombe Hospital
P.O. Box 145
15/06/2006

To all In charges

Dear Sir/Madam,

RE: ACCEPTANCE LETTER

This is to inform you that Mr. Tom Mulegi , a post graduate student from Kampala International University has been accepted to carry out research in the health Sub-district. Any assistance accorded to him will be highly appreciated.

.....

Dr. Lule Haruna
I/C HSD

BUTAMBALA HEALTH SUB-DISTRICT MPIGI
BOX 145
MPIGI
DATE.....

KAMPALA
INTERNATIONAL UNIVERSITY

P.O.BOX 20000
KAMPALA- UGANDA.
TEL:-041-266813

OFFICE OF THE DIRECTOR
SCHOOL OF POST-GRADUATE STUDIES

26Th May, 2006

The In Charge
Butambala Health Sub-District
MPIGI

RE: INTRODUCTORY LETTER FOR MR. MULEGI TOM MA-PT-2004-08

The above mentioned, is our student in the School of Post Graduate Studies. He is doing a Masters in Development Administration and Management (MA DAM)

Tom is currently doing his research on "The Impact of Decentralized Health Services on Development of a Rural Community" as a final requirement for the award of Master in Development Administration and Management of Kampala International University.

Any assistance accorded to him will be highly appreciated.

Thank you very much for your services.

PROF. PETER JOHN OPIO
DIRECTOR SPGS RESEARCH

Annex 5

Questionnaire

The researcher is a Post Graduate student of KIU carrying a research on the impact of decentralized Health services Management on the livelihoods of rural communities, as part of the requirement for the award of a master's degree in Development Administration and Management. Dear respondent, you are kindly requested to spare some few minutes of your precious time and participate in filling this questionnaire. All the information received will be treated with utmost confidentiality

Background

Health unit.....

Title.....

Sex.....

Time spent in health unit.....

Ownership.....

(Public, Government, PNFP, Private, others specify)

Sub-County .....

MANAGEMENT STRUCTURES AND DECENTRALIZATION

1. Are there any established Health management structures in Mpigi district?

a) Yes [] b) Not sure [] c) No []

If yes, what are these management structures?

.....

.....

2. Do you have the health management committee in your place?

.....

.....

a) If yes, how is this committee constituted?

.....

b) If no, why?.....

c) What is the criterion for choosing the membership?

.....

.....

3. Have meetings been held in the past 12 months?

.....

.....

a) If yes, how many times?

.....

.....

b) How is the Agenda for these meeting set?

.....

.....

4. Were the following stakeholders involved in the development of the Health plan, and what was the role of each?

(Tick appropriate box)

a) Village health team (if in place)	Yes	[]	Not sure	[]	No	[]
b) Staff of the health facility	Yes	[]	Not sure	[]	No	[]
c) Health unit management committee	Yes	[]	Not sure	[]	No	[]
d) Health Sub-district	Yes	[]	Not sure	[]	No	[]
e) The Community Based Health workers	Yes	[]	Not sure	[]	No	[]

Other specify.....

5.a) What advantages do you get from the above named stakeholders in the planning process?

.....

.....

b) What problems if any do you encounter from their involvement in the planning process?

.....

.....

c) If any, how have you tried to solve these problems?

.....

.....

6. Have you submitted any reports or forms to the District/HSD in the past 12 months?

.....

.....

a) If yes, how often do you submit these reports?

.....

.....

b) What problems if any do you encounter in the process of submission of these reports?

.....

.....

7. Have you received any feed back from the District/HSD level (such as reports, graphs, comparisons with statistics from other facilities) in response to reports or forms that were submitted in the past 12 months?

.....

.....

a) How is the feedback sent?

.....

.....

b) Do you also send feedback to the lower units/communities?

Yes [] Not sure [] No []

c) Does the feedback help you in the planning process?

d) If yes, how?

.....

.....

c) Does the feedback at times hamper your performance and how?

.....

.....

HEALTH ACTIVITIES/SERVICES PROVIDED BY HEALTH UNITS/CENTERS

1. What are the five diseases that had the highest occurrence rates in this facility in the past calendar year?

a).....

b).....

c).....

d).....

e).....

2. Health activities carried out at the health unit/center basing on the minimum activity package (MAP)

Element	Expected standard	Yes	Not sure	No
1) Control if Communicable diseases				
a) Malaria	Treatment following treatment guidelines			
	Health education			
b) STI/HIV/AIDS services	Diagnosis and treatment according to standard STI treatment guidelines			
	Promotion and provision of condoms to Prevent STIs			
a) Ante-natal & obstetric care	Do you operate routine ANC services			
	Identification of high risk cases			
	Promotion of good nutrition			
	Vaccination			
c) Family planning services	Provision of family planning, counceling and selected family planning methods of the client choice, health education on MCH/FP			
4) Other public health measures				
a) Environmental health	Promotion of hygiene practices in households, institutions and public places			
b) Health education and promotion	Control of mosquito breeding sites and other vectors Raising awareness on mental health in the community prevention and control of			
c) school health	School health outreaches to promote hygiene and health life styles among children			
	School supervision to ensure adequate latrines and water facilities			
	Regular medical examination of school children			

Source: primary data

The relationship between decentralization and health service delivery

1. Are there any community structures relating to health other than the HUMC operating in the community (Tick in the appropriate box)

a) Yes [] b) Not sure [] c) No []

b} If yes what are these structures?

.....

.....

c) How is each of these structures constituted?

.....

.....

d) What is there role in Health service delivery?

.....

.....

2. Are there guideline on their relationship with the health facility?

a) Yes [] b) Not sure [] c) No []

b) How are these guidelines developed?

.....

.....

b) Do these guidelines help you in the planning and management of health services and how?

.....

.....

3a). Does the community have access to the following mechanism for providing feedback to the health staff on quality and relevance of health services provided?

Suggestion box	a) Yes	[]	b) Not sure	[]	c) No []
Review of complaints	a) Yes	[]	b) Not sure	[]	c) No []
Involvement of community	a) Yes	[]	b) Not sure	[]	c) No []
Representative to meetings	a) Yes	[]	b) Not sure	[]	c) No []
User satisfaction survey	a) Yes	[]	b) Not sure	[]	c) No []

Other specify.....

b) Does the community understand the importance of such mechanisms?

.....

.....

c) If yes what makes you think that they value these mechanisms?

.....

.....

d) How does any of the mechanisms used above, impact both positively and negatively on the planning, management and delivery of health services?

.....

.....

4. Does the health facility undertake collaborative activities with traditional birth attendants/practitioners in the catchments areas?

a) Yes [] b) Not sure [] c) No []

b) If yes, how does this relationship help in the planning and delivery of health service delivery?

.....

.....

c) What possible problems have you encountered in this relationship and how has it affected your planning and delivery of services?

5. Do traditional birth attendants refer patterns to the health facility?

a) Yes [] b) Not sure [] c) No []

b) How has this referral affected the planning and delivery of heath services?

.....

.....

6. Are the following documents available in your health facility to the DHMT during supervision?

Supervision plan or schedule

a) Yes [] b) Not sure [] c) No []

Reports of past supervision visits

a) Yes [] b) Not sure [] c) No []

b) How have the documents mentioned above affected the planning and delivery of health services?

.....

.....

7a). what mechanisms does the health facility staff use to refer patients to other health facilities?

Referral feedback reports (from a lower to a higher level)

Other specify.....

b) How does this referral affect the planning and delivery of health services?

.....

.....

8. Do you have a health management information system (HMIS) database at the Health unit/ HSD/District?

a) Yes [] b) Not sure [] c) No []

b) How does this affect the planning and delivery of health services?

.....

.....

9a) do you have fees for service in the HSD/Health unit?

.....

.....

b) Are there any fees for service (user charges) clearly displayed for all clients to see?

a) Yes [] b) Not sure [] c) No []

c) How does this impact positively on the planning and delivery of health services?

.....

.....

d) How does this impact negatively if any on the planning and delivery of health services?

.....

.....

e) What has been the community response to fees for service?

.....

.....

10 Have you benefited from the services ?

.....

.....

If yes, how?

.....

.....

If no , how

.....

.....

THANK YOU FOR YOUR COOPERATION