

**COMMUNITY PARTICIPATION IN PLANNING, IMPLEMENTATION,
MONITORING AND EVALUATION ON HEALTH SERVICE
DELIVERY IN MBARARA CITY, UGANDA**

BY

MUGABE ARTHUR KANYONYI

23/BSU/MAPAM/0561

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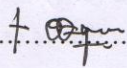
DECLARATION

I MUGABE ARTHUR KANYONYI registration number 23/BSU/MAPAM/0561 hereby declare that this dissertation is my work and has never been presented to any University or Institution of learning for any academic award.

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APPROVAL

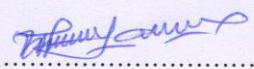
This research was carried out by **MUGABE ARTHUR KANYONYI** registration number **23/BSU/MAPAM/0561** under my supervision at Bishop Stuart University.

Signature: 

..... 29/09/2025

RT. REV. ASSOC. PROF. FRED SHELDON MWESIGWA

Date

Signature: 

..... 27/09/2025

DR. ROBERT TURAMUREEBA (PhD)

Date

DEDICATION

I dedicate this dissertation to my beloved wife, whose unwavering support and encouragement have been my greatest strength. To my parents, who instilled in me the values of perseverance and hard work, and to my brothers and sisters, whose constant prayers and belief in me have been a source of inspiration. To my dear daughters, whose love and joy have given me purpose. This work is a testament to all that you have done for me.

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TABLE OF CONTENTS

DECLARATION	Error! Bookmark not defined.
APPROVAL	i
DEDICATION	ii
LIST OF ABBREVIATIONS.....	viii
LIST OF TABLES.....	ix
LIST OF FIGURE.....	x
ABSTRACT	xi
CHAPTER ONE	1
INTRODUCTION	1
1.1 Introduction.....	1
1.1 Background of the study	1
1.1 Historical Background	1
1.1.2 Theoretical Background.....	3
1.1.3 Conceptual Background.....	4
1.1.4 Contextual Background	5
1.2 Problem Statement	5
1.3 General objective	7
1.4 Specific objectives	7
1.6 Research hypothesis.....	7
1.7 Conceptual framework.....	8
1.8 Justification of the Study	8
1.9 Significance of the study.....	9
1.10 Scope of the Study	10
1.10.1 Content Scope	10
1.10.2 Time Scope	10
1.10.3 Geographical Scope	10

CHAPTER TWO	11
LITERATURE REVIEW	11
2.1 Introduction.....	11
2.2 Actual review	14
2.2.1 Influence of community participation in planning of Health Service Delivery.....	14
2.2.2 Influence of community participation in implementation of Health Service Delivery	15
2.2.3 Influence of community participation in monitoring and evaluation of Health Service Delivery.....	17
2.4 Summary of literature review	19
CHAPTER THREE	21
METHODOLOGY	21
3.1 Introduction.....	21
3.3 Study Population	21
3.4 Determination of the Sample Size	21
3.5 Sampling Techniques and procedures	22
3.6 Data collection methods.....	23
3.6.1 Questionnaire survey	23
3.6.2 Interview method	23
3.7 Data collection instruments.....	23
3.7.1 Questionnaire	23
3.7.2 Interview guide	24
3.8 Reliability and Validity.....	24
3.8.1 Reliability.....	24
3.8.2 Validity	25
3.9 Procedure for data collection	26
3.10 Data analysis	27
3.9 Ethical consideration.....	27

CHAPTER FOUR.....	28
PRESENTATION, INTERPRETATION AND ANALYSIS OF THE FINDINGS	28
4.1 Introduction.....	28
4.2 Response rate	28
4.2 Background information of the respondents.....	29
4.3 Health Service Delivery in Mbarara City	31
4.4 Contribution of community participation in planning of Health Service Delivery in Mbarara City	35
4.5 Correlation analysis between community participation in planning of Health Service Delivery in Mbarara City	40
4.6 Community participation in implementation and Health service delivery	41
4.7 Correlation analysis between Community participation in implementation and Health service delivery	45
4.8 Community participation in monitoring and evaluation, and Health service delivery.	47
4.9 Correlation analysis between Community participation in monitoring and evaluation, and Health service delivery	51
4.10 Linear regression.....	54
CHAPTER FIVE	57
SUMMARY OF THE FINDINGS, DISCUSSION AND RECOMMENDATION.....	57
5.1 Introduction.....	57
5.2 Summary of the findings.....	57
5.2.1 Community participation in Planning on Health service delivery.....	57
5.2.2 Community participation in implementation on health service delivery	57
5.2.3 Community participation in monitoring and evaluation on health service delivery.....	58
5.3 Discussion	59
5.3.1 Community participation in Planning on Health service delivery.....	59
5.3.2 Community participation in implementation on health service delivery	60
5.3.3 Community participation in monitoring and evaluation on health service delivery.....	62

5.4 Conclusion	63
5.4.1 Community participation in planning on Health service delivery	63
5.4.2 Community participation in implementation on health service delivery	64
5.4.3 Community participation in monitoring and evaluation on health service delivery	64
5.5 Recommendations	65
5.5.1 Community participation in Planning on health service delivery	65
5.5.2 Community participation in implementation on health service delivery	65
5.5.3 Community participation in monitoring and Evaluation on health service delivery	65
5.6 Contribution to knowledge	65
5.7 Areas for further Research	81
References	66
APPENDICES	75
Appendix A: Questionnaire	75
Appendix A: Interview guide	80

LIST OF ABBREVIATIONS

HC IVs:	Health Centre IV
M&E:	Monitoring and Evaluation
MOH:	Ministry of Health
SPSS:	Statistical Package for Social scientist
VHTs:	Village Health Teams

LIST OF TABLES

Table 3. 1 Target population and sample size.....	22
Table 3. 2 Reliability analysis.....	25
Table 3. 3 Validity analysis	26
Table 4. 1 Response rate for data instruments	28
Table 4. 2 Demographic characteristics.....	30
Table 4. 3 Descriptive statistics of quality of Health service delivery	32
Table 4. 4 Descriptive statistics for contribution of community participation in planning of Health Service Delivery in Mbarara City.	35
Table 4. 5 Correlation analysis results between community participation in planning of Health Service Delivery.....	40
Table 4. 6 Descriptive statistics for the extent to which community participation in implementation of Health Service Delivery in Mbarara City.....	42
Table 4. 7 Correlation analysis results between Community participation in implementation and health service delivery.....	46
Table 4. 8 Descriptive statistics for community participation in monitoring and evaluation, and Health service delivery.....	48
Table 4. 9 Correlation analysis between Community participation in monitoring and evaluation and health service delivery	53
Table 4. 10 Model Summary	54
Table 4. 11 ANOVA.....	54
Table 4. 12 Multiple regression coefficients.....	55

LIST OF FIGURE

Figure 1: Conceptual framework showing community participation and health service delivery.....	8
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ABSTRACT

This study examined the contribution of community participation to Health Service Delivery in Mbarara City. Specifically, it assessed how community involvement influences planning, implementation, and monitoring and evaluation of health services. The study was guided by Representative Democracy Theory and Stakeholder Theory and employed a cross-sectional design incorporating both quantitative and qualitative approaches. A sample of 210 respondents, including community members and key health officials, was selected using a combination of simple random and purposive sampling, with a response rate of 206. Data were collected via questionnaires for community members and interviews for key informants. Quantitative data were analyzed using descriptive and inferential statistics, while qualitative data were analyzed through content analysis using NVIVO software. Findings indicate a weak positive but significant relationship between community participation in planning and health service delivery, a strong positive influence during implementation, and a moderate positive effect in monitoring and evaluation. The study further found out that active and well-structured community participation in both the planning and implementation of health service delivery enhances the relevance, utilization, and effectiveness of interventions. Engaging residents in identifying priorities and decision-making ensures appropriate resource allocation, fosters ownership, strengthens transparency and accountability, and builds trust between the community and service providers. Adequate training, clear roles, and empowered community representatives are essential for effective engagement, while limited involvement can result in misaligned priorities and reduced service impact. Overall, integrating community voices and supporting their participation is critical for responsive, coordinated, and high-quality healthcare delivery in Mbarara City. The study recommends establishing volunteer health committees, participatory feedback mechanisms, and community scorecards to enhance accountability, resource allocation, and overall quality of health services. These measures can strengthen community ownership and improve the responsiveness of health programs.

Keywords: Community participation, Health service delivery, Planning, Implementation, Monitoring and evaluation, Mbarara City, Stakeholder engagement.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter covers the background of study, problem statement, general study, research objectives, research hypotheses, conceptual framework, justification, significance and scope of the study.

1.1 Background of the study

The background to the study is structured in four perspectives; historical, theoretical, conceptual and contextual background as detailed in the sub-sections below;

1.1 Historical Background

Health Service Delivery is traced way back in 1854, when there was high mortality rates among British troops who suffered Cholera and diarrhoea infections (Lambert, 2016). Health Service Delivery was done through the removal of Calvary horses that were being stabled in the hospital basement, ensuring the sewers leading from the hospital was flushed several times a day and disinfecting the latrines/drains with peat charcoal. According to Hahn and Sheingold (2016), Health Service Delivery among British troops was also done by linking hand-washing and cleanliness to disease reductions as well as sensitizing the community members.

Since the 1980s, a great number of Countries, developed or developing, have been embarking on improving the quality of public service delivery through decentralization whereby legally Uganda embraced the move in 1997 through the enactment of the Local Government Act, 1997 Amended (Golola, 2001). In June 1985, a WHO inter-regional meeting on Community Involvement in Health was held on the island of Brioni in Yugoslavia with the intention of improving the health standards of developed and developing countries. In response to regional and global calls for community participation in the management of primary health care, Ministries of Health in developing countries, in the early 1990s, established health committees to enhance participation of communities in the planning and development of primary health care and education programs (Karuga et al., 2022).

In Africa, since 1905 up to 1960, Health Service Delivery was generally fair and completely free (Ncube, 2017). The colonialists provided free medical care, free consultation, free immunization, free maternal and child services for Africans, and emergency care for children under-five years as well as free health insurance for them, strengthened by an accelerated

combat against the epidemics of the time. However, during independence times and post-independence times, Health Service Delivery began to deteriorate due to corruption and frequent wars (Azevedo, 2017). Later towards the 1990s, private health services began to mushroom with an intention of increasing accessibility to health services so as to match the demands of the increasing population (Mintzberg, 2017). However, Private health facilities made health services expensive and this still put the pressure on governments since majority of the African population was poor and could not afford the costs (Turshen, 2019). Currently effective Health Service Delivery still remains a challenge in almost 54 African countries (Mayosi et al., 2012). Many African countries have health committees, which have the potential to be effective structures for active community participation in pursuit of universal health coverage by monitoring progress, identifying and solving problems and re-planning health priorities (Boulle, 2013). Since health committees consist mostly of individuals from the community, they focus on quality services for their community and local health priorities.

In Sub-Sahara Africa, countries such as Ghana, Nigeria, Kenya and Uganda aspire to achieve universal access to healthcare for their citizens (Obago & Naravage, 2021). Involvement of communities, through health committees, in the delivery of primary health services is essential for countries to achieve this aspiration (Marston et al., 2016). There is, however, limited knowledge on how health community committees contribute to health service in Sub Saharan Africa (McCoy, Hall & Ridge, 2012).

From the 1960s to the mid-1970s, Uganda had one of the most effective public service systems in sub-Saharan Africa (Nabanoba, 2005). The country's health system in particular, was one of the finest, with an effective referral system from the village dispensaries and district hospitals to the national referral hospital. During the 1970s and early 1980s, many of these institutional systems collapsed, resulting in substantial deterioration of the health outcome indicators (Kasim, 2019).

By 1986, the health sector was in a state of near collapse, with dilapidated and very poorly equipped public health facilities (Mayanja, 2005). Healthcare workers in the public sector were demoralized due to very low and irregular wages, and in addition, public funding for the sector was unreliable (Kyaddondo & Whyte, 2003). While several reforms have been undertaken in the health sector with a view to improving health outcome indicators, progress has stagnated since the late 1990s. The immediate reform emphasis was on the rehabilitation

of the existing facilities to restore functional capacity, and shift of emphasis to primary health care, in order to improve service delivery (Ondoa, Basheka & Basaasa, 2013).

1.1.2 Theoretical Background

The study was guided by two theories that is Representative Democracy Theory and Stakeholder Theory;

The Representative Democracy Theory that was propounded by Locke in the 1680s. The theories hypothesize that (all) people whom a particular decision affects should participate in the making of such decisions so that their interests can be embraced through their representatives (Samah & Aref, 2011). Citizen participation can therefore be construed to be direct in the classical democratic sense or indirect - through (elected) representatives to voice citizens' views in a pluralist-republican democratic model (Kweit & Kweit, 1986).

The theory posits that policies in democratic processes should be evaluated against accessibility of the (policy) process and responsiveness of the policies to those it affects rather than on their mere efficiency or rationality to (local) governments (LG). This theory fit the instant study to the magnitude that citizen participation would lead to the outcome that citizens' desire in terms of efficiency and availability of health services.

The stakeholder theory suggested by Freeman in 1984. Stakeholder theory is based on the notion that beyond shareholders there are several agents with an interest in the actions and decisions of companies. The theory identifies stakeholders as groups and individuals who benefit from or are harmed by, and whose rights are violated or respected by, corporate actions. In addition to stakeholders include revenues, politicians, suppliers, and the communities at large.

The theory asserts that companies have a social responsibility that requires them to consider the interests of all parties affected by their actions. Management should not only consider its shareholders in the decision making process, but also anyone who is affected by business decisions (Branco & Rodriques, 2007). The main assumption of the stakeholder theory is that an organization's effectiveness is measured by its ability to satisfy not only the shareholders, but also those agents who have a stake in the organisation (Gomes, 2006).

This theory was relevant because it advocates for involvement of stakeholders in health centers from planning stage, implementation, monitoring and evaluation. This theory helped in relating community involvement to Health Service Delivery.

1.1.3 Conceptual Background

Community participation refers to the active involvement of community members in decision-making processes, activities, and initiatives that affect their lives and the well-being of their community (Mamokhere & Meyer, 2023). It is an essential element of democratic governance and community development, emphasizing inclusivity, collaboration, and empowerment.

Community in planning refers to the active involvement of community members in the urban or regional planning processes that shape the physical, social, and economic development of their neighborhoods, towns, or cities (Mehlape, 2022). It emphasizes the importance of including diverse perspectives, local knowledge, and community priorities in decision-making to create more inclusive, equitable, and sustainable urban environments.

Community involvement in implementation refers to the active engagement of community members in the actual execution and realization of plans, projects, policies, or initiatives that have been collectively decided upon through community participation in the planning process (Omiti & Moi, 2024; Mehlape, 2022). It emphasizes the importance of community ownership, collaboration, and empowerment throughout the implementation phase to ensure that outcomes are responsive to local needs, sustainable, and beneficial to all community members.

Community involvement in monitoring and evaluation (M&E) refers to the active engagement of community members in the process of assessing and reviewing the progress, outcomes, and impacts of projects, programs, or policies that affect their community (Omiti & Moi, 2024). This participatory approach to Monitoring and Evaluation goes beyond traditional methods by including local knowledge, perspectives, and priorities, thereby enhancing the relevance, effectiveness, and sustainability of interventions.

Health Service Delivery refers to the provision of healthcare services to individuals and communities to promote, maintain, and restore health (Pradhan, Najmi & Fatmi, 2022). It encompasses a wide range of activities, from prevention and health promotion to diagnosis, treatment, rehabilitation, and palliative care. Effective Health Service Delivery ensures that essential health interventions are accessible, affordable, equitable, and of high quality.

1.1.4 Contextual Background

The Health Service Delivery system in Uganda is decentralized, with districts, cities, municipalities, town councils and sub-counties playing a key role in the provision of health care. The private sector also plays a large role in the provision of services through private not-for-profit organizations and practitioners. Public health facilities account for more than half (55%) of all 5,200 facilities in Uganda, while private-not for-profit and private-for-profit facilities account for 17% and 29% respectively. While 85% of the population resides in rural areas and mostly utilizes public facilities, providers are inequitably concentrated in urban areas and health workers in rural areas.

The Health Service Delivery in Uganda is under decentralisation basing on the constitution of Uganda which stipulates that all services must be decentralized (Constitution of Uganda, 1995). One of the services is health services where decentralisation was expected to deliver better access to health services, better quality of health care and, ultimately decline in the rate of illness and death. The health system in Uganda is decentralised in such way that health services flow from ministry of Health, National Referral Hospital, Regional Referral Hospital, General Hospital, Health Centre IV, Health Centre III, Health Centre II to Village health team (Local Government Act, 1997 as Amended).

Mbarara City has full mandate of planning and controlling Health Centre IV, Health Centre III, Health Centre II to Village health team to delivery health services. However, there is constant shortage of drugs and other medical facilities in health centres which compromises the provision of quality and timely health service delivery to the residents of Mbarara City. People have also registered complaints about inadequate waste management facilities that have become a health hazard to the people living around these areas (Mbarara City Report 2022-2023). The Mbarara City Abstract report (2020) also highlighted that there is high child and maternal mortality rate at 10 per 100 lives and high prevalence of diseases. Whether such scenarios are linked to decentralisation, there is little empirical evidence to give a detailed account. This study established the contribution of community participation in planning, implementation, monitoring and evaluation on health service delivery in Mbarara city, Uganda.

1.2 Problem Statement

Community participation is known to significantly influence Health Service Delivery (Ankunda, 2018). Government of Uganda has ensured community participation in terms of

planning, implementation, monitoring and Evaluation to Health Service Delivery (Muhwezi et al., 2019). In the same context, Mbarara City has improved Health Service Delivery systems by partnering with The AIDS Support Organisation to improve the Health service Delivery (Asasira, 2017). The Government has also increased salaries for all health workers by 100%, upper graded Health centers II's to HCIII's, deployed Health information Management System in HC IVs to collect and monitor the patients data files (Johnson, Gershom & Justus, 2021). Mbarara City has collaborated with VHTs to reach out to community members so that they can have access to better medical services (Kangwagye et al., 2023).

Despite several interventions, health service delivery in Mbarara City faces challenges in quality, utilization, accessibility, and outcomes. Turyahabwe et al. (2020) found poor incident reporting among healthcare providers, compromising patient safety. Muramuzi (2024) reported that 84.3% of diabetic patients had poor glycemic control due to low outpatient attendance and long waiting times. Accessibility is limited, as the hospital's 600 beds serve 12 districts and neighboring regions, causing high patient loads. Health outcomes remain suboptimal; only 66% of deliveries occur in health units (UBOS, 2021). In case this trend persists, the patient mortality rates and malnutrition may accelerate hence causing health crisis in the Uganda. Related studies which were conducted such as Marston, Renedo and Miles (2020) found out that community participation is essential in the collective response to coronavirus disease 2019 by identifying solutions: providing insight into stigma and structural barriers; and devising collective responses. Similarly, Musoke et al. (2021) highlighted that community health workers play a vital role in mobilization and referral in tackling non-communicable diseases. However, such studies are largely disease-specific and focus on emergency or specialized interventions rather than the broader, routine health service delivery challenges faced at the city level. This raises critical questions about community participation in quality of service, sustainability of health services, utilization of services, accessibility of health services, and overall health delivery outcomes without clear evidence, existing interventions risk remaining top-down and technocratic, failing to leverage the collective agency of communities in improving their own health outcomes. It was this gap that justifies an in-depth investigation into the contribution of community participation in planning, implementation, monitoring and evaluation on health service delivery in Mbarara city, Uganda.

1.3 General objective

To establish the contribution of community participation in planning, implementation, monitoring and evaluation on health service delivery in Mbarara city, Uganda.

1.4 Specific objectives

- i. To find out the contribution of community participation in planning on Health Service Delivery in Mbarara City
- ii. To determine the contribution of community participation in implementation of Health Service Delivery in Mbarara City.
- iii. To find out the contribution of community participation in monitoring and evaluation of Health Service Delivery in Mbarara City.

1.6 Research hypothesis

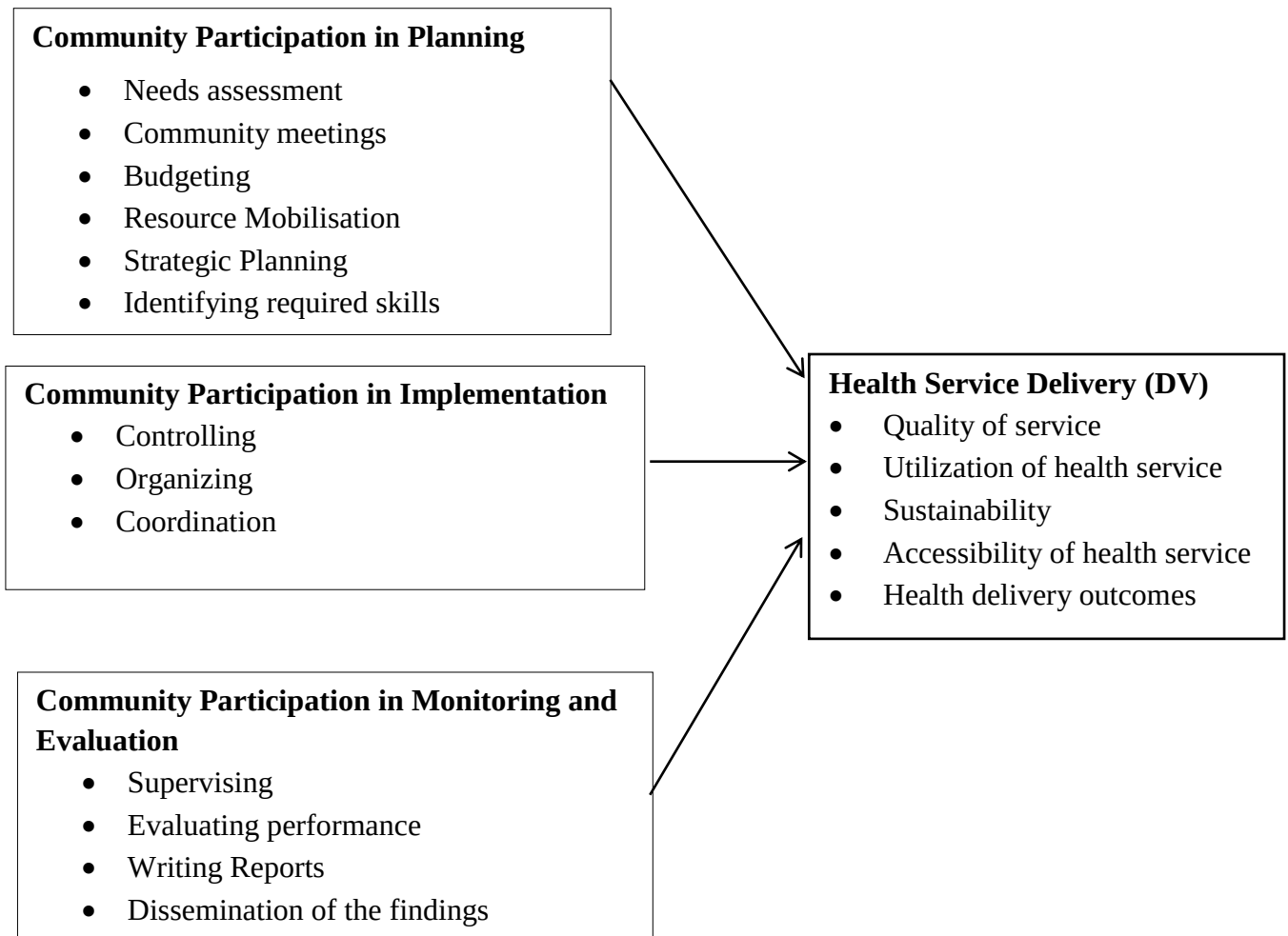
H1: Community participation in planning contributes to Health Service Delivery

H2: Community participation in implementation contributes to Health Service Delivery

H3: Community participation in monitoring and evaluation contributes to Health Service Delivery

1.7 Conceptual framework

The conceptual framework postulates the linkage between community participation in planning, implementation, monitoring and evaluation on Health Service Delivery.



Source: O’Riordan and Fairbrass (2014) and modified by researcher (2024).

Figure 1: Conceptual framework showing community participation and health service delivery

1.8 Justification of the Study

This study is important because it aims at investigating the contribution of community participation on Health Service Delivery in Mbarara City. Previous related studies have explored various aspects of healthcare improvements: Esmaeilzadeh (2020) studied the use of Artificial Based tools for healthcare purposes, Usak et al. (2020) examined healthcare service delivery based on the Internet of Things, and Wulandari, Sriwahyuni, and Gunawa (2023) investigated the impact of quality management on patient satisfaction at Montella Private Hospital in the West Aceh district. In Uganda, Lugada et al. (2022) assessed the status and performance of the health supply chain system across health facilities. Mulumba, et al. (2021)

studied decolonizing health governance in Uganda Musoke et al. (2021) conducted Community health workers' involvement in the prevention and control of non-communicable diseases in Wakiso District, Uganda. Beebwa et al. (2021) studied the role of community health nursing in identifying needs of women and children under five in Katete, Mbarara-Uganda. However, there is limited knowledge on community participation and Health Service Delivery in Mbarara City hence the study.

1.9 Significance of the study

This study will enable the central Government and the management of and health service delivery in Mbarara City to determine the contribution of community participation to Health Service Delivery in Mbarara City.

It will also help the district management committee to understand what community participation should be enhanced to enhance health service delivery and contribute to meeting the National Development Goals.

There can be a number of academicians, organizations and researchers who would like to know what decentralization constructs are available in health service delivery in Mbarara City and how they relate to health service delivery which is on a high demand by the citizens.

The study findings will be source of literature for scholars interested in conducting further research on health service delivery, particularly in exploring other interventions such as resource mobilization, or in examining additional factors that influence the effectiveness of health systems.

The study could act as a wake-up call for the MOH and other pertinent healthcare authorities to enhance capacity and systems for improving the health care, aligning with the recommendations outlined in the study.

The understandings obtained from the research will aid the government and other stakeholders in the healthcare system in crafting new policies aimed at enhancing efficiency through the adoption of both new and existing technologies in healthcare centers. This, in turn, will elevate the quality of Health Service Delivery across government healthcare settings.

1.10 Scope of the Study

1.10.1 Content Scope

The study was limited to examining the contribution of community participation to health service delivery in Mbarara City. Specifically, it focused on assessing the influence of community participation in the planning, implementation, and monitoring and evaluation of health service delivery.

1.10.2 Time Scope

This research aimed to look at data collected over a period of two years, from 2022 to 2024. This is the period when the Health Service Delivery worsened within Mbarara City (Mbarara City report, 2023).

1.10.3 Geographical Scope

The study was carried out in Mbarara City. Mbarara City is a city in the Western Region of Uganda and the second largest city in Uganda after Kampala. The city is divided into 6 boroughs of Kakoba Division, Kamukuzi Division, Nyamitanga Division, Biharwe Division, Kakiika Division, Nyakayojo Division. It is the main commercial centre of most of south western districts of Uganda and the site of the district headquarters. The coordinates of the Mbarara central business district are 00 36 48S, 30 39 30E (Latitude:-0.6132; Longitude:30.6582).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter examined literature related to community participation and Health Service Delivery. The literature is reviewed in accordance with the relevant theories and objectives of the study under the following themes; contribution of community participation in planning of Health Service Delivery; contribution of community participation in implementation of Health Service Delivery and contribution of community participation in monitoring and evaluation of Health Service Delivery in Mbarara City.

2.2 Theoretical Review

The Representative Democracy Theory that was propounded by Locke in the 1680s. The applicability of the Representative Democracy Theory, propounded by Locke in the 1680s, has been demonstrated in various empirical and conceptual studies that highlight the role of citizen participation in policy and service delivery. The theory assumes that all individuals affected by a decision should participate in making it, either directly or indirectly through representatives (Samah & Aref, 2011).

Abelson et al. (2013) in their study on *public participation in health care priority setting in Canada* found that citizens' involvement improved the legitimacy and acceptability of health decisions. This demonstrates the theory's applicability in ensuring that policies reflect the voices and needs of those they affect.

Martin (2008) explored *representativeness, legitimacy, and power in public involvement in health-service management in England*. The study showed that when patients and communities are represented in health decision-making processes, the resulting services are more responsive and widely accepted, reflecting the theory's emphasis on representation and responsiveness.

Marston, Renedo, and Miles (2020) examined *community participation during the COVID-19 pandemic*. They found that collective participation helped identify barriers and devise solutions for equitable health responses, showing that representative structures and inclusive participation lead to more effective policy outcomes.

Musoke et al. (2021) investigated the role of *community health workers in preventing and controlling non-communicable diseases in Uganda*. They concluded that community representatives (health workers) are vital in mobilization and referral, reinforcing Locke's assumption that participation—whether direct or through representatives—strengthens service delivery. Lee (2023) empirically established a relationship between democratic governance, citizen participation, and improved health outcomes such as reduced infant mortality. This broad evidence shows that representation and accountability in democratic systems lead to more responsive and effective health services, thus confirming the theory's applicability in the governance of public health.

Several scholars have noted inherent weaknesses in this model. One major limitation is the risk of elitism and power concentration. As theorists such as Dahl (1989) argue, representative systems often empower a small political or economic elite rather than the wider population, creating inequality in decision-making. The Pew Research Center (2024) similarly found that many citizens across the globe believe elected officials “do not care what people like them think,” underscoring the persistent disconnect between representatives and those they are supposed to serve. This detachment challenges the theory's original assumption that representatives act in the best interests of all constituents.

The limitations of representation are also visible in the health sector in low- and middle-income contexts. For instance, Musoke et al. (2021) highlight how, in Uganda, community health workers often struggle to bridge the gap between local populations and formal health systems due to resource constraints and limited decision-making power. Similarly, a study on shared decision-making in rural Uganda (BMC Medical Ethics, 2025) found that low literacy, cultural barriers, and hierarchical health structures reduce genuine participation of patients in shaping services. These findings illustrate how the weaknesses of representative democracy such as misrepresentation, exclusion, and tokenism directly undermine service delivery outcomes, particularly in health systems where inclusiveness and accountability are critical.

Stakeholder theory

The study was guided by stakeholder theory suggested by Freeman in 1984. Stakeholder theory is based on the notion that beyond shareholders there are several agents with an interest in the actions and decisions of companies. The theory was applied by the following studies.

Kyomuhangi et al. (2024) examined the impact of stakeholder engagement on the quality of healthcare service delivery in government hospitals in Lyantonde District, Uganda. The study found that inadequate stakeholder involvement during planning, implementation, and monitoring phases contributed to substandard healthcare services. The authors emphasized that structured consultations and participatory approaches could enhance community involvement and improve overall service delivery, highlighting the critical role of stakeholders in shaping responsive and effective health systems.

Amuni et al. (2025) explored stakeholder participation in monitoring and evaluation (M&E) of donor-funded projects in informal settlements in Kisumu Central Sub-County, Kenya. The findings revealed that regular stakeholder interactions and opportunities to contribute to project development significantly improved project performance. However, the study also noted that stakeholders' inputs were not always fully incorporated into programming, suggesting that effective engagement requires not only consultation but also systematic integration of stakeholders' perspectives into decision-making processes.

Petkovic et al. (2023) focused on stakeholder engagement in the development of health and healthcare guidelines. Their study identified key considerations for effective engagement, including defining roles, determining levels of participation, documenting contributions, evaluating processes, and managing conflicts of interest. The findings highlighted that inclusive and transparent engagement ensures that stakeholders' inputs are meaningfully reflected in guideline development, thereby improving legitimacy, acceptability, and applicability of health policies.

Laurisz et al. (2023) examined stakeholder involvement in the context of Healthcare 4.0, emphasizing the transformation of healthcare services through digitalization and innovation. The research highlighted the roles of multiple stakeholders medical personnel, labor unions, insurance providers, and patients in shaping future healthcare services. The study underscored that collaborative engagement enables stakeholders to address challenges, leverage opportunities, and co-create solutions, demonstrating the value of comprehensive participation in modernizing healthcare systems.

Franco-Trigo et al. (2020) conducted a systematic scoping review on stakeholder analyses in health innovation planning. The study concluded that identifying key actors, understanding their interests and influence, and facilitating collaborative decision-making are essential for

the success and sustainability of health innovations. The review emphasized that comprehensive stakeholder engagement improves decision-making processes and ensures that health innovations are responsive to the needs and expectations of all relevant actors.

2.3 Actual review

2.2.1 Influence of community participation in planning of Health Service Delivery

Planning is the process of defining objectives of the health centres operational activities needed to achieve the set objectives. This implies that the planning process describes activities, set targets, cost, time, scope and indicators which act as a guide on how to achieve the objectives and goal thus ideal service delivery. Planning helps to specify both material and human resources needed for successful implementation and monitoring and evaluation of the services rendered (Igwe et al, 2018).

Community participation in planning activities such as meetings, budgeting, setting up targets and support the organizations' activities improves service delivery. Community participation in planning creates a sense of ownership among clients which enables them to work tirelessly to ensure good health service delivery (Atwijukire, Kyohairwe, & Kiwanuka, 2015). Participation fosters transparency and accountability. When community members have a say in decision-making processes, they are more likely to hold organizations accountable and ensure that resources are used effectively (Shields et al., 2021).

According to Nyabera (2015) participation of community in planning is vital for the smooth implementation of health projects and lack of their participation in planning may affect Health Service Delivery. This implies that when community are involved in planning, they will clearly understand the expected deliverables within a specified cost, time frame, scope and deliverables based on quality standards. In health centers where the community is never involved in planning activities, such as coming up with the cost of activities, and where in-charges assume that their clients have nothing to do with cost later affect the service delivery.

Kajoba (2016) undertook a study on establishing the extent to which community participation in the oil exploration planning process has influenced service delivery in Buliisa district of Uganda. Therefore, according to the results there was a positive significant relationship between community participation in the oil exploration planning process and service delivery. This shows that the results from the oil exploration cannot be generalized on the Health Service Delivery in Mbarara City thus content gap.

Adewale and Esther (2012) reveal that community s' involvement in the strategic planning has a positive significant effect on service delivery on the effect of community s' involvement in the strategic planning on service delivery in the University of Venda and to determine how different community s are involved in the strategic planning. This implies that the results from University of Venda cannot be utilised and generalized on Health Service Delivery in Mbarara City thus geographical gap.

Okot, Basheka and Kweyamba (2011) conducted the study on the influence of community's' participation on quality service delivery in Case Med Care, a medical scheme owned and managed by Case Medical Hospital in Kampala. The findings revealed that the overall community especially in planning had a positive influence on quality of healthcare. This implies that the results from health centres in Kampala cannot be generalized on Health Service Delivery in Mbarara City thus geographical gap.

Kugonza and Mukobi (2015) studied how community participation in local planning affects service delivery in Buikwe District local government, the results found that overall community' participation in planning local government projects positively influenced service delivery by 42% respectively based on Pearson Correlation Coefficient. The study further found that information is not readily accessible or effectively disseminated to the majority of citizens and therefore is not fully harnessed for planning, monitoring and evaluating government projects.

Gambe (2013) researched about community participation in health service provision drawing lessons from Msasa Park, Harare, Zimbabwe revealed that service delivery in Harare had deteriorated. More so, the study revealed that the attributable reason was failure to engage the residents of Msasa Park in the process of planning and finding solutions to the health problems of Harare. They felt sidelined and this had caused a very poor relationship between the residents and city fathers. This implies that the results from health centres in Msasa Park, Harare, Zimbabwe cannot be generalized on Health Service Delivery in Mbarara City thus geographical gap.

2.2.2 Influence of community participation in implementation of Health Service Delivery

Mphako (2013) studied public participation and service delivery: citizen participation in implementing infrastructural programs in Ingquza Hill Municipality in South Africa which is

concerned with the interaction between communities and government in the exercise of providing services, revealed that public participation in implementation of infrastructural programs in the Ingquza Hill Municipality strongly enhanced the delivery of services. Stumbraitė-Vilkišienė (2012) on the study about citizen participation in the local public service provision and quality improvement in Municipalities of the Republic of Lithuania revealed that citizens involvement in the project implementation process not only because of good governance but also in order to receive input for increasing the quality of local policies and quality of services.

Le, Vu, Hens and Van Heur (2014) studied community participation in the implementation of the environmental management system (EMS) to tackle environmental issues and ensure compliance with regulations, three ports in Vietnam and two ports in Cambodia. The findings show that while ports are perceived as sources of environmental problems, they are also seen as important economic powerhouses since involving the port community s in implementation of the system would make it much easier for them to access its services.

Mehlape (2022) noted that the presence of the community or their elected representatives on project steering committees or boards or other supervisory or decision-making bodies empowers the community to play an active role in project implementation. Also, technical training and assistance to build the community's capacity for organizational and technical responsibilities during project implementation contribute to community's empowerment and improves chances for project sustainability once the technical and managerial assistance is withdrawn.

Mnqayi (2021) noted that involvement of people in implementation and the utilization of local resources generate a sense of ownership over the development interventions by the local people thereby promoting sustainability of the project. Identification of key community leaders is a part of the project implementation process, and consists of assigning individuals and groups who are affected by the project or use it. Adequate and appropriate strategies can then be designed and implemented to enhance the positive influence of community participation in sustainability. This becomes a fundamental risk management issue for project managers and failing to establish a comprehensive connection between risks related to project and community participation will lead likely to project failure (Mehlape, 2022). It is therefore very important for the community leaders to be involved in the implementation of projects because this will help in service delivery.

Community participation in implementation is one of the most important exercise in managing and sustaining projects. Community participation during the implementation stage facilitate the coordination of people, efficient utilization of resources and effective evaluation of risks to carry out the established project plan. For instance, Magero and Muchelule (2019) suggest that community participation in project implementation is necessary to transform the planned programs and objectives of a project into realistic well-structured tasks and activities to achieve the project goals.

According to Mnqayi (2021), the performance of development project is largely depending on the attitudes of different community members. Hence, during the implementation, if key community members are not committed to adequately execute their responsibilities, it will adversely impact the overall project performance and sustainability. Mnqayi (2021) continued that the stakeholder's participation like community is highly important to project success, and therefore taking account their claims and interests during the project implementation stages is largely required to achieve project objectives and sustainability.

Basing on the majority of the above studies, it was also inferred that community participation in implementation is related to Health service delivery. However, no study linked the same variables in the field of health service delivery and more specifically in Mbarara City and Uganda at large. Still most of the above studies considered only company employees as the unity of inquiry. Therefore, this study hypothesized that *“there is no statistically significant relationship between community participation in implementation and Health Service Delivery in Mbarara City”*. So this study will find out whether there is a contribution of community participation in implementation on health service delivery.

2.2.3 Influence of community participation in monitoring and evaluation of Health Service Delivery

Monitoring and evaluation refers to the periodic and continuous review of activities guided by work plan and analysis of output against set targets in relation to cost, scope time and quality (Okafor, 2021). Monitoring involves tracking progress of the activities against the budget, time frame, scope and output based on quality and identifying any bottlenecks and lesson learnt for improvement (Igwe & et al, 2018).

Nyabera (2015) conducted a study on influence of stakeholder participation on implementation of projects in Kenya in Compassion International Assisted Projects in

Mwingi Sub-County and found out that there is there is a strong relationship between community participation in monitoring and evaluation and service delivery. To ensure service delivery, community must be involved in monitoring activities such as knowing the schedules, which activities are to be executed, when, where, which resources are required, what are the objectives (scope), how much time is needed and knowing whether the standard operating procedures are available to ensure delivery of quality outputs. Community is vital in giving feedback about the project activities and services which enables members understand whether the activities are on track of achieving its set objectives and targets based on the community's feedback which might be negative or positive feedback.

Kananura et al. (2017) studied community participation in monitoring and evaluation and Health service delivery focusing maternal and newborn babies' department in eastern Uganda hospitals. The results revealed that Community participation in M&E eased service delivery by identifying emerging issues, such as weak implementation by some village health teams, health facility constraints such as poor use of standard guidelines, lack of placenta disposal pits, inadequate fuel for the ambulance at some facilities, and poor care for low birth weight infants. As a result, the sub-county leadership constructed placenta disposal pits, the district health officer provided fuel for ambulances, and health workers received refresher training and mentorship on how to care for newborns.

Community sense of ownership in relation to monitoring has been cited as a key influence in attaining sustainability. The community is expected to participate and contribute inputs either in kind or financial from the design to completion. Kwenya & Moronge (2015) assert that providing an environment where communities participate freely, improves their knowledge and perception about the project subsequently contributing to service delivery. Community participation in monitoring and evaluation is beneficial to a project's efficiency and sustainability. To this end, there has been increased attention on participatory monitoring and evaluation in projects including rural water supplies (United Nations, 2017). Participatory monitoring and evaluation in project life cycle management is thus proposed as a pathway to sustainability (Sulemana et al., 2018).

According to United Nations Report (2017), community participation in Monitoring & Evaluation is critical in project sustainability since it offers new ways of assessing and learning from change that are more inclusive and more responsive to the needs and aspirations of those most directly affected.

The joint inspection and reporting assure that processes are followed and transparency is promoted in managing projects, ultimately, contributing to sustainability (Sulemana, Musah, & Simon, 2018). In reference to a study funded by the Agha Khan Rural Support Programme in Northern Pakistan, Jha et al. (2019) indicate that those projects managed by the community had a better performance compared to those operated by the local government. Likewise, Muniu, Gakuu and Rambo (2017) elaborate that enhanced sustainability in rural areas is attainable by ensuring that projects meant to serve the community are managed by the community members. The empirical contributions from these scholars thus affirm the impact of community participating in monitoring and evaluation contributes to service delivery.

Basing on the majority of the above studies, it was also inferred that community participation in monitoring and evaluation is related to service delivery. However, no study linked the same variables in the field health service delivery and more specifically in Mbarara City and Uganda at large. Still most of the above studies considered only company employees as the unity of inquiry. Therefore, this study hypothesized that “*there is no statistically significant relationship between community participation in monitoring and evaluation and Health Service Delivery in Mbarara City*”.

2.4 Summary of literature review

In summary, the literature indicates that community participation in planning significantly influences health service delivery by ensuring that policies and programs reflect the real needs and priorities of local populations. Studies by Marston, Renedo, and Miles (2020) and Musoke et al. (2021) emphasize that involving communities during the planning stage helps identify gaps in health services, allocate resources efficiently, and reduce disparities in access and quality. Through participatory planning, communities can voice their concerns, which strengthens the relevance and responsiveness of health interventions.

Regarding community participation in implementation, evidence shows that active involvement of local actors including community health workers, local committees, and volunteers enhances the delivery of services, mobilizes resources, and promotes adherence to health programs. Musoke et al. (2021) demonstrate that community actors play a pivotal role in mobilizing patients, providing health education, and facilitating referrals, which improves service utilization and health outcomes. Participation in implementation also fosters community ownership, accountability, and sustainability of health initiatives.

Finally, community participation in monitoring and evaluation is critical for improving accountability and service quality. Studies such as Abelson et al. (2013) and Martin (2008) highlight that when communities are involved in monitoring health programs, they can provide feedback on service delivery gaps, drug availability, and staff responsiveness. This ensures that health interventions remain relevant and adaptive to changing needs. Moreover, participatory monitoring strengthens transparency, reduces mismanagement of resources, and empowers communities to hold service providers accountable, thereby contributing to improved health service delivery outcomes.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This Chapter guides the data collection process. It presents the research design and its description, study population in terms of its number and position, sample size by number and sampling procedures, a description of the data collection methods. It also presents the instruments used for data collection on Health Service Delivery, data quality assurance, research procedure, measurement of variables, data analysis and ethical considerations are equally presented.

3.2 Research Design

The study used a cross-sectional study design that incorporates both qualitative and quantitative approaches to examine how community participation affect health service delivery in Mbarara City. The qualitative technique of data collection helped in exploring people's experiences, narrates people's stories, and helps in providing in-depth data. The qualitative approach involved collecting and analysing the non-numerical data to understand people's perception. The quantitative approach provided figures and their significance that will aid in description of the quality Health service Delivery (Hunziker & Blankenagel, 2024). The researcher adopted this kind of research design because it provides a clear image of the current situation at the health facilities and thus be able to unearth the community participation and Health Service Delivery in Mbarara City.

3.3 Study Population

Study population refers to the entire group of individuals, objects, or events that share a common characteristic and are the focus of the study (Sileyew, 2020). According to Yarkoni (2022), population as the entire set of individuals, events or objects with common observable characteristics about the generalization research that was made. This study population included the community members, City Health Officer, Health in charges, city mayor, RCCs, VHTS and city councilor. These target populations have entire common observable characteristics about the generalization research (Mugenda & Mugenda, 2003).

3.4 Determination of the Sample Size

The sample size is defined as the number of observations used for determining the estimations of a given population (Lakens, 2022). The researcher will use a sample size of

215 respondents which includes community members, City Mayor, Finance personnel and City Clerk. The 433 respondents was determined using the Krejcie and Morgan Table (1970).

Table 3. 1 **Target population and sample size**

SN	Category of Population	Population size	Sample Size	Sampling Technique
1	Community members	420	201	Simple random Sampling
3	City Health Officer	1	1	Purposive
4	Health in charges	5	5	Purposive
5	City Mayor	1	1	Purposive
6	Secretary for Health	1	1	Purposive
7	RCCs	1	1	Purposive
8	VHTS	5	5	Purposive
	Total	434	215	

Source: Mbarara City Council Human Resource manual (2024)

3.5 Sampling Techniques and procedures

3.5.1 Simple random sampling

Rahman (2023) defines Simple random sampling as sampling technique that gives respondents an equal chance of being selected for a given sample. Rahman (2023) found that simple random sampling allows the selection of a good sample of respondents for a study. Simple random sampling is a strategy where every element in the population has a known and equal chance of being selected as a subject (Lohr, 2021). Simple random sampling was employed on Community members because it ensures that each member of the target population has an equal and independent chance of being included. The researcher gave a random number to every object or member of the accessible population placing the number in the container and then pick any number at random; the subject corresponding to the picked number was included in the sample. If the number was picked the second time it was ignored. The process was repeated until the required number of the sample size is obtained (López, 2023). This technique used to select the community members.

3.5.2 Purposive sampling

Purposive sampling is a technique in which the required information is gathered from special or specific targets or groups of people on some rational basis (Sekaran, 2003). The researcher chooses the participants as per his/her own judgment, keeping back in mind the purpose of the study (Showcat & Parveen, 2017). The study also used purposive sampling to select City Health Officer, Health in charges, City Mayor, Secretary for Health, VHTs and RCC due to their perceived knowledge arising out of known experience that they have. The category of participants to provide the required information are City Health Officer, Health in charges, city mayor and city councilor because they are key in delivering services.

3.6 Data collection methods

The data collection methods included a questionnaire survey and interviews.

3.6.1 Questionnaire survey

This method was used to collect data from community members because it is cost-effective and tends to achieve a higher response rate (Amin, 2005). Additionally, it is capable of reaching a large number of participants in a short time, allows participants sufficient time to respond to the items, provides a sense of anonymity, and is objective, thereby eliminating bias from personal characteristics.

3.6.2 Interview method

The researcher prepared and use an interview guide to conduct interviews with City Health Officer, Health in charges, city mayor and city councilor. Interviews method is chosen because they are believed to provide in-depth information about a particular research issue or question. According to Mugenda and Mugenda (2003), interviews provide in-depth data which is not possible to get using questionnaires. It is preferred because it provides more detailed information about the study questions and allows for probing in cases of ambiguous responses (Mugenda & Mugenda, 1999). Additionally, this method was chosen for these participants because the researcher aims to capture in-depth, accurate, and sensitive information that cannot be obtained through questionnaires (Mugenda & Mugenda, 2003).

3.7 Data collection instruments

3.7.1 Questionnaire

A Questionnaire survey method is a research method for collecting information from the selected group using standardized Questionnaires (Amin, 2005). Syed (2016) defines questionnaire survey as a technique for gathering statistical information about the attributes,

attitudes or actions of a population through a structured set of questions. Oso and Onen (2008) assert that questionnaire is a collection of items to which a respondent is expected to fill/react in writing. Community members will self-administer a questionnaire consisting of close-ended questions presented in a five-point Likert scale format (5-Strongly Agree, 4-Agree, 3-Neutral, 2-Disagree, 1-Strongly Disagree). This tool was selected by the researcher based on Mugenda and Mugenda's (1999) assertion that questionnaires enable unbiased responses, are cost-effective, and can efficiently reach a wide audience in a brief timeframe. The questionnaire primarily addressed the study variables concerning community participation on Health Service Delivery.

3.7.2 Interview guide

Amin (2005) defines an interview as an oral inquiry in which the investigator collects data through direct verbal interaction with participants. Interview method with questions related to study was used to collect data from key informants. Oso and Onen (2008) state that an interview method is a person to person verbal communication in which one person or a group of persons asks the other questions intended to elicit information or opinion. The interview manual, featuring open-ended questions, will complement the data obtained from the questionnaire. This instrument favored for City Health Officer, Health in charges, city mayor and city councilor because it allows the researcher to conduct thorough investigations through detailed probing on the research topic, given their presumed first-hand knowledge about the Health Service Delivery.

3.8 Reliability and Validity

3.8.1 Reliability

Reliability is also concerned with repeatability whereby a scale or test is said to be reliable if repeat measurement made by it under constant conditions will give the same result (Hamed & Kuala, 2016). Amin (2005) argues that reliability is the dependability or trustworthiness in the context of measuring instruments. For the reliability of the instrument, a pilot study is done together with pre-testing the questionnaire and interview guide, to a few respondents other than the target respondents, normally around 10%. These few questionnaires were entered in SPSS and a reliability test done there and then and a value above 0.7 depicts a reliable instrument and one which is less than 0.7 calls for adjustments to be done until it produces a better reliability value over several numbers of presentations. Either way, reliability of the instruments can be tested using Cronbach Alpha Coefficient.

Table 3. 2 Reliability analysis

Variables	Cronbach Alpha
Planning	0.831
Implementation	0.712
Monitoring and Evaluation	0.822
Quality Health service delivery	0.753
Average	0.779

Source: Primary data

The results in Table 3.2 indicate that all the study variables achieved Cronbach's alpha values above the recommended threshold of 0.70, which demonstrates good internal consistency. Specifically, planning (0.831), implementation (0.712), monitoring and evaluation (0.822), and quality health service delivery (0.753) all reflect reliable measurement scales. The overall average alpha of 0.779 further confirms that the research instrument was dependable and capable of consistently capturing the constructs under study. According to Amin (2005), a reliability coefficient of 0.70 or higher is considered acceptable, suggesting that the items used in the questionnaire were clear, relevant, and appropriate for measuring the intended variables. This implies that the responses obtained are trustworthy and provide a solid foundation for further statistical analysis.

3.8.2 Validity

The tools of data validity is suitability for measuring a variable or construct and producing the planned results (Amin, 2005). Validity assessment was conducted to evaluate the accuracy with which the instrument represents the ideas being examined (Amin, 2005; Mugenda & Mugenda, 1996). Amin's method for creating the content validity index (CVI) was employed.

The CVI = $\frac{\text{Number of items regarded relevant by all judges}}{\text{Total number of items in the instrument}}$

Table 3. 3 Validity analysis

Variables	Items considered	Valid Items	CVI
Planning	10	8	0.8
Implementation	10	7	0.7
Monitoring and Evaluation	10	9	0.9
Quality Health service delivery	14	12	0.857
Average			0.814

Source: Primary data

The Table 3.3 shows that validity of the instruments was assessed using the Content Validity Index (CVI), which measures the extent to which the items in a questionnaire or interview guide adequately capture the constructs under study. In this study, the CVI for all instruments was 0.814, indicating a very high level of validity, as Amin (2005) recommends that a CVI of 0.70 and above reflects an acceptable level of content validity.

Qualitatively, conformability in qualitative research ensured whereby the degree to which the outcomes could be confirmed or corroborated by other people (Onwuegbuzie et al., 2012). After collecting data, interviews was transcribed and then analyzed with the help of an expert in qualitative research to confirm whether the transcripts relate to the audio-taped interview. At another stage, the study will corroborate with the developed themes and sub-themes with the transcripts to check consistence.

3.9 Procedure for data collection

The researcher obtained an introductory letter from the school of management science of Bishop Stuart University (BSU) that was taken to the City Clerk to seek permission to conduct the study. Staff at the city was selected purposively to inform the study and also identify some of the community members in health services. Before conducting interviews, research assistants was hired and trained to support the data collection process, thereafter respondents was informed about the research objectived to prepare them make well-grounded decisions on whether to participate or not. Interviews and focus group discussion were held with respondents after asking for informed consent.

3.10 Data analysis

Data collected using questionnaire was coded, entered into the computer using Statistical Package for Social Scientist version 29 and cleaned for quality assurance. Quantitative data was the analyzed using descriptive and inferential statistics to derive relevant descriptive statistics (Frequencies and percentages) which was additionally analyzed in order to attain relevant conclusions and was presented using tables. Descriptive statistics was used to find out the means and frequencies of responses while inferential statistics was computed using Pearson correlation in order to show the strength and direction of the association.

Qualitative data collected using interview guide was analysed using thematic content analysis with NVIVO software which was done by reading through each transcript carefully to identify and eliminate bias; the transcripts was interpreted by labelling relevant words, phrases, sentences, or sections with codes.

3.9 Ethical consideration

Informed consent of the respondents was used to make choice to participate in the study or not. Each respondent had a right to decline or discontinue participating in the research at any time and at will.

The subjects had a right to anonymity that is conceal information about them-selves that feel would be sensitive and private. To safeguard the privacy of subjects, the researcher used the names but only the relevant demographic information as well as random code numbers in the case of interviews.

The participant's confidentiality was guaranteed: that there was protection of information given and that the data collected was treated with total confidentiality. To ensure this, the researcher listed the data using number codes rather than names.

Data Protection: The researcher explained and assured the participants that the information given in the study was to be used for academic purposes only.

CHAPTER FOUR

PRESENTATION, INTERPRETATION AND ANALYSIS OF THE FINDINGS

4.1 Introduction

This chapter includes the presentation, analysis and interpretation of the findings of the study which was to establish the contribution of community participation on Health Service Delivery in Uganda specifically Mbarara City. The findings include the background information of the participants and descriptive statistics.

4.2 Response rate

Basing on the instruments that were used for data collection, some filled questionnaires were not returned for analysis as illustrated in the Table 4.1 below.

Table 4. 1 Response rate for data instruments

Instruments	Target sample	Responses	Percentage
Community members	201	198	98.5%
City Health Officer	1	1	100%
Health in charges	5	5	100%
City Mayor	1	1	100%
Secretary for Health	1	1	100%
VHTs	5	5	100%
RCC	1	1	100%
Total	215	212	98.6%

Table 4.1 presents data on the utilization of two research instruments, interviews, and questionnaires with a total sample size of 215 participants. The questionnaires were distributed to 201 individuals and 198 responses were received, yielding a higher return rate of 98.5%. The overall findings indicate that out of the total sample size of 215 expected responses, 212 responses were collected, constituting 98.6% response rate.

Achieving a research response rate of 70% or above is generally considered robust and indicative of a high level of participant engagement, thereby enhancing the internal validity

of the study (Dillman, Smyth, & Christian, 2014). A response rate within this range suggests that the sample is more likely to be representative of the target population, minimizing the risk of non-response bias and increasing the reliability of the study's findings. A higher response rate contributes to the credibility of the research results, as it reflects a more comprehensive and inclusive data collection process (Groves, Cialdini & Couper, 1992).

4.2 Background information of the participants

In order to understand the data characteristics and ensure that the sample covered the different dimensions of the study, the researcher explored the background information of the respondents. The background characteristics helped to know that the information given is credible, dependable, truthful, reliable, transferable and conformable by respondents who participated in the study. In this section, respondents provided information on their age, gender, marital status, occupation, education level and working experience. The results about the background of the respondents are presented in Tables 4.2

Table 4. 2 Demographic characteristics

Variable	Sub-Variable	Frequency (n=198)	Percent
Sex	Male	86	43.4
	Female	112	56.6
Age	18-35	65	32.8
	36-50	43	21.7
	51-60	56	28.3
	> 60 years	34	17.2
Education	Primary	62	31.3
	Secondary	41	20.7
	Tertiary	48	24.2
	Under graduate	33	16.7
	Others	14	7.1
Period having services with Health Centre	Below five years	41	20.7
	5-10 years	72	36.4
	10 years above	85	42.9

Source: Field data (2024)

Table 4.2 indicate that 56.6% majority of the respondents were females whereas 43.4% were males. This implies that females are more involved in accessing the health services from the government facilities than males hence they had much contribution in this study.

Table 4.2 shows that majority (82.8%) were in age brackets of below 60 years (18-35 + 36-50 + 51-60 years). Thus, an indication of community members of Mbarara City of the productive age are engaged in accessing health services from public health centers.

It was found out that majority (31.3%) of the participants were primary level, 24.2% were tertiary, 20.7% were secondary, 16.7% were under graduate and 7.1% were from different education levels such as Post graduate diploma and PhD. This suggests that the study was informative in nature and had different education background thus the accuracy of the data by filling the right information.

The results from Table 4.2 shows that (42.9%) majority of the respondents had used health facilities for at least 10 years, 36.4% for 5-10 years and 20.7% for less than five year. This implies that majority of the respondents had used the public facilities for at least 10 years.

4.3 Health Service Delivery in Mbarara City

The findings are presented objective by objective using descriptive statistics of frequencies, percentages and means to find out the frequency and percentage of the variables. All the variables were measured on a five-point Likert scale ranging from 1-Strongly Disagree (SD), 2 – Disagree (D), 3 – Not Sure (NS), 4 – Agree (A) and 5 - Strongly Agree (SA). In this study Strongly Agree and Agree were taken to mean Agree and Strongly Disagree and Disagree were taken to mean Disagree. A mean above 3 indicates an agreement of respondents, a mean of 3 shows agreement and a mean below 3 shows disagreement by respondents. The standard deviation (Std) of close to 1 show agreement, while the standard deviation of close to Zero shows the disagreement of the respondents. The elicited responses are shown in the Table 4.3.

Table 4. 3 Descriptive statistics of quality of Health service delivery

Quality of Health Service Delivery	SD	D	NS	A	SA	Mean
Mbarara City health officials ensure good sanitation both in health centres and in communities	28 (14.1%)	56 (28.3%)	6 (3%)	47 (23.7%)	61 (30.8%)	3.29
Mbarara City health officials sensitize communities on good nutrition habits	69 (34.8%)	74 (37.4%)	8 (4%)	18 (9.1%)	29 (14.6%)	2.31
The city health officials have reduced mortality rates	65 (32.8%)	55 (27.8%)	8 (4%)	38 (19.2%)	32 (16.2%)	2.58
The necessary health equipment are always readily available and in good working conditions	98 (49.5%)	82 (41.4%)	–	7 (3.5%)	11 (5.6%)	1.74
The health centers in this district have a well-equipped laboratory	68 (34.3%)	56 (28.3%)	9 (4.5%)	39 (19.7%)	26 (13.1%)	2.49
The health centers in this city have equipment for dealing with emergency	26 (13.1%)	34 (17.2%)	5 (2.5%)	63 (31.8%)	70 (35.4%)	3.59

Source: Field data (2025)

Table 4.3 shows that 28 (14.1%) strongly disagreed, 56 (28.3%) disagreed, 6 (3%) were neutral, 47 (23.7%) agreed and 61 (30.8%) strongly agreed that Mbarara City health officials ensures good sanitation both in health centres and in communities. The mean of 3.29 shows that majority of the respondents agreed with the statement. This shows that the notion of always available health services is ideal, it necessitates careful consideration of sanitation in Mbarara City.

The study's quantitative findings highlight the varying levels of influence that community participation has on different stages of primary health care service delivery. Qualitative insights from Key Informant E supported this observation, stating that,

“Most health projects are planned at the city level with minimal input from the communities. Sometimes we are only informed when the project is about to start, which limits our ability to suggest relevant priorities.”

The implication is that without structured and consistent community engagement in the planning phase, health initiatives risk low acceptance, poor utilisation, and limited impact, as they may not adequately address the actual needs and preferences of the intended

beneficiaries.

It was also found out that 69 (34.8%) strongly disagreed, 74 (37.4%) disagreed, 8 (4%) were neutral, 18 (9.1%) agreed and 29 (14.6%) strongly agreed that Mbarara City health officials sensitize communities on good nutrition habits. The mean of 2.31 shows that of the respondents disagreed with the statement. This implies that the majority of respondents perceive limited or insufficient efforts by health officials in promoting good nutrition practices among the community. The high proportion of disagreement (72.2%) suggests a communication gap between health authorities and the public regarding nutrition education. This could hinder the adoption of healthy eating habits, weaken preventive health. Qualitative insights from Key Informant F supported this finding, noting that although nutrition education is occasionally integrated into outreach programs, it is not prioritised due to resource constraints and competing health demands such as immunisation and disease control. The informant further observed that limited funding for community health promotion and the absence of dedicated nutrition officers make it difficult to sustain consistent and targeted sensitisation on healthy eating practices.

Table 4.3 indicates that 65(32.8%) strongly disagreed, 55 (27.8%) disagreed, 8 (4%) were neutral, 38 (19.2%) agreed and 32 (16.2%) strongly agreed that the city health officials have reduced mortality rates. The mean of 2.58 shows that of the respondents had mixed feelings (neutral) about the statement. This indicates that reduced availability may discourage individuals from seeking preventive care or routine check-ups, increasing the risk of developing serious health issues in Mbarara City. Qualitative insights from Key Informant F echoed this concern, stating that,

“While there have been efforts to address causes of preventable deaths, limited medical personnel, inadequate equipment, and delays in emergency response still contribute to mortality. In rural divisions especially, people often arrive at health centres too late for effective intervention.”

This implies that while policy and programmatic efforts to reduce mortality exist, their impact is constrained by systemic challenges such as human resource shortages, inadequate medical infrastructure, and delays in emergency response. Without addressing these structural barriers, the gains in reducing preventable deaths in Mbarara City are likely to remain limited, particularly in rural divisions where access barriers are more pronounced.

The results in Table 4.3 further indicate that 98 (49.5%) strongly disagreed, 82 (41.4%)

disagreed, 7 (3.5%) agreed and 11 (5.6%) strongly agreed that necessary health equipment are always readily available and in good working conditions. The mean of 1.74 shows that of the respondents disagreed with the statement. This implies that patients with critical conditions are referred to other facilities to ease the burden on healthcare systems thus community members loose trust in the quality of health services health facilities in Mbarara City offers. Qualitative insights from Key Informant A supported this finding, stating that,

“Most health centres lack functioning diagnostic machines, reliable oxygen supply, and sometimes even basic delivery kits. This forces referrals for even manageable cases, which delays treatment and frustrates patients.”

The implication is that without significant investment in procuring, maintaining, and regularly servicing essential medical equipment, the perceived and actual quality of healthcare will remain low, further eroding public confidence and increasing the strain on referral facilities.

Table 4.3, indicates that 68 (34.3%) strongly disagreed, 56 (28.3%) disagreed, 9 (4.5%) were neutral, 39 (19.7%) agreed and 26 (13.1%) strongly agreed that health centers in this city have a well-equipped laboratory. The mean of 2.49 shows that of the respondents disagreed with the statement. This indicates that inadequate access to regular health services in the laboratory decrease the need for emergency care which is costlier and resource-intensive in Mbarara City.

Qualitative insights from Key Informant B reinforced this concern, stating that;

“Many laboratories in our health facilities are either missing critical testing machines or have them broken down for months. Patients are often sent to private labs far away, which delays diagnosis and treatment.”

The implication is that without functional and well-equipped laboratories within city health facilities, timely diagnosis and preventive interventions will remain limited, leading to higher treatment costs, delayed care, and poorer health outcomes for the community.

The results shows that 26 (13.1%) strongly disagreed, 34 (17.2%) disagreed, 5 (2.5%) were neutral, 63 (31.8%) agreed and 70 (35.4%) strongly agreed that health centers in this city have equipment for dealing with emergency. The mean of 3.59 shows that of the respondents agreed with the statement. This implies that majority of respondents (67.2%) believe that health centers in Mbarara City are adequately equipped to handle emergencies. The high level

of agreement suggests a generally positive perception of the city's emergency preparedness. However, the presence of some disagreement (30.3%) indicates that not all health centers may be equally equipped, pointing to the need for continued investment and uniform distribution of emergency medical equipment.

Qualitative insights from Key Informant D confirmed this finding, stating that, *“Most of our main health centres now have basic emergency kits like oxygen cylinders, stretchers, and first aid supplies, but advanced life-saving equipment is still limited to the referral hospital.”* The implication is that while the availability of basic emergency equipment in city health centres has improved, the lack of advanced life-support machines and specialised tools restricts the capacity to manage severe cases on-site, necessitating referrals that can delay critical interventions.

4.4 Contribution of community participation in planning of Health Service Delivery in Mbarara City

The study aimed at determining the contribution of community participation in planning of Health Service Delivery in Mbarara City. Quantitative data was computed to determine means that show the average and central tendency responses in each question of Likert scale which were asked to respondents. The findings were presented in Table 4.4.

Table 4. 4 Descriptive statistics for contribution of community participation in planning of Health Service Delivery in Mbarara City.

Community participation in planning	SD	D	NS	A	SA	Mean
Community members are always consulted by city health officials before health projects are started	55 (27.8%)	48 (24.3%)	7 (3.5%)	42 (21.2%)	46 (23.2%)	2.88
Community members help in identifying all possible disease out breaks and other needs related	81 (40.9%)	72 (36.4%)	6 (3%)	19 (9.6%)	20 (10.1%)	2.12
The health services given to communities base on their identified needs	32 (16.2%)	38 (19.2%)	9 (4.6%)	61 (30.8%)	58 (29.3%)	3.38
Mbarara City requests community members to compile a list of health resources needed in advance	12 (6.1%)	17 (8.6%)	6 (3%)	85 (42.9%)	78 (34.4%)	4.01
The city health officials schedule meetings with community members to discuss the health requests and their objectives.	–	–	–	94 (47.5%)	104 (52.5%)	4.53

The city health officials inform different groups about the sources of income for health related projects.	–	–	–	105 (53.1%)	93 (46.9%)	4.47
The city health officials inform community members of the necessary expenditures related to health	56 (28.3%)	48 (24.2%)	7 (3.5%)	48 (24.2%)	39 (19.7%)	2.83
Community members participate in writing the health project proposals in city	25 (12.6%)	36 (18.2%)	8 (4%)	57 (28.8%)	72 (36.4%)	3.58
Community members are involved in either signing or preparing the financial documents related to health services in this city	73 (36.9%)	83 (41.9%)	6 (3%)	22 (11.1%)	14 (7.1%)	2.10

Source: Field data (2025)

Table 4.4 shows that 55 (27.8%) strongly disagreed, 48 (24.3%) disagreed, 7 (3.5%) were neutral, 42 (21.2%) agreed and 46 (23.2%) strongly agreed that Community members are always consulted by city health officials before health projects are started. This implies that respondents are divided in their views, with a slight majority (52.1%) disagreeing, suggesting that community consultation may not be consistently practiced. The results point to a possible gap in participatory planning, where some community members feel excluded from decision-making processes in health interventions. This could affect the relevance, ownership, and sustainability of health projects in the Mbarara city.

The study's quantitative findings highlight the varying levels of influence that community participation has on different stages of primary health care service delivery. Qualitative insights from Key Informant E supported this observation, stating that,

“Most health projects are planned at the city level with minimal input from the communities. Sometimes we are only informed when the project is about to start, which limits our ability to suggest relevant priorities.”

The implication is that without structured and consistent community engagement in the planning phase, health initiatives risk low acceptance, poor utilisation, and limited impact, as they may not adequately address the actual needs and preferences of the intended beneficiaries.

Table 4.4 shows that 81 (40.9%) strongly disagreed, 72 (36.4%) disagreed, 6 (3%) were neutral, 19 (9.6%) agreed and 20 (10.1%) strongly agreed that community members help in

identifying all possible disease out breaks and other needs related. The mean of 2.12 shows that majority of the respondents disagreed with the statement. This implies that non-participatory processes create perceptions of secrecy and lack of accountability, eroding public trust in Mbarara City thus affecting the Health service Delivery.

The findings indicate that community participation in monitoring and evaluation of health services is often limited, which can hinder timely responses to public health issues. Qualitative insights from Key Informant A confirmed this challenge, stating that,

“Often, disease surveillance is handled internally by the health department without actively involving community leaders or residents. By the time information reaches the public, the outbreak may already be spreading.”

The implication is that excluding community members from early disease detection efforts limits timely reporting and coordinated response, increasing the risk of uncontrolled outbreaks and undermining the credibility of the health system.

It was believed that 32 (16.2%) strongly disagreed, 38 (19.2%) disagreed, 9 (4.6%) were neutral, 61 (30.8%) agreed and 58 (29.3%) strongly agreed that health services given to communities base on their identified needs. The mean of 3.38 shows that majority of the respondents agreed with the statement. This implies that a majority of respondents (60.1%) agree that health services are responsive to community needs, indicating a positive perception of service relevance and alignment with local priorities. However, the presence of 35.4% who disagreed suggests that some gaps may still exist in needs assessment or service delivery, warranting improved community engagement and needs-based planning to ensure inclusivity and effectiveness.

Table 4.4 shows that 12 (6.1%) strongly disagreed, 17 (8.6%) disagreed, 6 (3%) were neutral, 85 (42.9%) agreed and 78 (34.4%) strongly agreed that Mbarara City requests community members to compile a list of health resources needed in advance. The mean of 4.01 shows that majority of the respondents agreed with the statement. This indicates that citizens holding leaders accountable leads to more informed and inclusive decision-making, as leaders seeks community input to justify their actions fostering the quality health service delivery in Mbarara City.

The study’s results suggest that involving communities in the planning stage positively influences the relevance and effectiveness of health service delivery. Qualitative insights

from Key Informant A aligned with this view, stating that,

“When health projects are being planned, some divisions now organise meetings where residents suggest what equipment or supplies are most needed. This has helped reduce wastage and ensured that new resources address real gaps.”

The implication is that maintaining and expanding such participatory resource planning processes can strengthen community ownership, improve resource allocation efficiency, and enhance the responsiveness of health services to actual needs.

The results in Table 4.4 indicates that 94 (47.5%) agreed and 104 (52.5%) strongly agreed that city health officials schedule meetings with community members to discuss the health requests and their objectives. The mean of 4.53 shows that majority of the respondents agreed with the statement. This implies that elected officials advocate more effectively for their communities at higher levels of government, amplifying local voices in broader policy discussions thus bridging health service delivery nearer to the community in Mbarara City.

The results in Table 4.4 indicate that 105 (53.1%) agreed and 93 (46.9%) strongly agreed that city health officials inform different groups about the sources of income for health related projects. The mean of 4.47 shows that majority of the respondents agreed with the statement. This indicates that local elections empower citizens by giving them a say in who makes decisions that affect their lives, fostering a sense of ownership over community issues with exception of Health service Delivery in Mbarara City.

It was found out that 56 (28.3%) strongly disagreed, 48 (24.2%) disagreed, 7 (3.5%) were neutral, 48 (24.2%) agreed and 39 (19.7%) strongly agreed that the city health officials inform community members of the necessary expenditures related to health. The mean of 2.83 shows that majority of the respondents had mixed feelings (neutral) about the statement. This implies that the central government is not transparent about its healthcare initiatives to encourage collaboration between local councils and health authorities thus hindering a unified approach to health challenges in Mbarara City. The study revealed that lack of clear communication and transparency in financial management can undermine effective community participation in health services. Qualitative insights from Key Informant A highlighted this issue, stating that;

“There is often limited communication from higher authorities about budget allocations and spending on health, which causes confusion and weakens

coordination among local stakeholders.”

The implication is that improving transparency and information sharing about health expenditures is essential to foster trust, strengthen partnerships, and enable more effective, coordinated health interventions across the city.

The results in Table 4.4 indicates that 25 (12.6%) strongly disagreed, 36 (18.2%) disagreed, 8 (4%) were neutral, 57 (28.8%) agreed and 72 (36.4%) strongly agreed that community members participate in writing the health project proposals in city. The mean of 3.58 shows that majority of the respondents agreed with the statement. This indicates that transparency in information sharing encourages community involvement and feedback, fostering a collaborative approach to health improvements in Mbarara City. Qualitative insights from Key Informant A supported this finding, stating that, *“Including community representatives in proposal development has increased trust and ensured that projects reflect the real needs and priorities of the people.”* The implication is that sustaining and expanding such participatory proposal-writing processes can improve project relevance, ownership, and ultimately, the success and sustainability of health interventions.

Table 4.4 shows that 73 (36.9%) strongly disagreed, 83 (41.9%) disagreed, 6 (3%) were neutral, 22 (11.1%) agreed and 14 (7.1%) strongly agreed that community members are involved in either signing or preparing the financial documents related to health services in this city. The mean of 2.10 shows that majority of the respondents disagreed with the statement. This indicates that citizens who are uninformed about local health initiatives that are less likely to participate in public health programs or advocating for their needs in accessing the quality Health service Delivery in Mbarara City. Qualitative insights from Key Informant A reinforced this concern, stating that;

“Financial management is often handled solely by officials, with little to no transparency or community involvement. This creates a disconnection and reduces community trust and engagement in health projects.”

The implication is that excluding community members from financial decision-making processes can undermine transparency and accountability, leading to decreased public trust and lower community participation in health programs, which ultimately hampers effective health service delivery.

4.5 Correlation analysis between community participation in planning of Health Service Delivery in Mbarara City

The first objective was to establish whether there was a relationship between community participation in planning and Health Service Delivery in Mbarara City, a correlation analysis was carried out. The results are presented in Table 4.5.

Table 4. 5 Correlation analysis results between community participation in planning and Health Service Delivery

		Community participation in Planning	Health Service Delivery
Community participation in planning	Pearson Correlation	1	.469**
	Sig. (2-tailed)		.000
	N	198	198
Health Service Delivery	Pearson Correlation	.469**	1
	Sig. (2-tailed)	.000	
	N	198	198

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

The Table 4.5 above presents the results of a Pearson Correlation analysis between Community participation in planning and health service delivery. The Pearson correlation coefficient (r) is 0.469, which indicates a weak positive correlation between Community participation in planning and the quality of Health service Delivery. This means that as Community participation in planning increases, health service delivery also tends to increase, and the reverse is true. The significance (P-value is 0.00 less than the standard threshold of 0.05). This means that the correlation is statistically significant. The statistics confirm the hypothesis that *"There is a relationship between Community participation in planning and Health service delivery in Mbarara City"* based on the statistical analysis. The two variables have a statistically significant and weakly positive association.

The evidence indicates that meaningful community participation in health planning can significantly enhance the effectiveness and sustainability of health programs. Qualitative insights from Key Informant F strongly support this finding, stating,

“When communities are genuinely involved in health planning, policies are more responsive and grounded in local realities. This participation leads to better resource allocation, ownership, and sustainability of health programs, as people feel their voices matter.”

The implication is that policymakers should prioritise structured community engagement mechanisms in health planning to ensure policies reflect the actual needs of residents. Embedding participatory approaches in policy formulation enhances transparency, accountability, and ultimately improves the effectiveness and acceptance of health service delivery in Mbarara City.

4.6 Community participation in implementation and Health service delivery

The study aimed at exploring the extent to which community participation in implementation influence Health Service Delivery in Mbarara City. Quantitative data was computed to determine means that show the average and central tendency responses in each question of Likert scale which were asked to respondents. All the variables were measured on a five-point Likert scale ranging from 1-Strongly Disagree (SD), 2 – Disagree (D), 3 – Not Sure (NS), 4 – Agree (A) and 5 - Strongly Agree (SA). In this study Strongly Agree and Agree were taken to mean Agree and Strongly Disagree and Disagree were taken to mean Disagree. A mean above 3 indicates an agreement of respondents, a mean of 3 shows agreement and a mean below 3 shows disagreement by respondents. The standard deviation (Std) of close to 1 show agreement, while the standard deviation of close to Zero show the disagreement of the respondents. The findings were presented in Table 4.6.

Table 4. 6 Descriptive statistics for the extent to which community participation in implementation of Health Service Delivery in Mbarara City

Community participation in implementation	SD	D	NS	A	SA	Mean
Community members are part of the health team that foresees the health services in Mbarara City	28 (14.1%)	33 (16.7%)	9 (4.6%)	61 (30.8%)	67 (33.8%)	3.54
The city health officials delegate community members to oversee some of their activities	38 (19.2%)	51 (25.8%)	8 (4%)	45 (22.7%)	46 (23.2%)	2.93
The district health officials are friendly and skilled in doing their work	–	–	5 (2.5%)	119 (60.1%)	74 (37.4%)	4.35
The city health officials have links with government and private technical bureaus for maintenance and supply of spare parts and repair services.	25 (12.6%)	32 (16.2%)	6 (3%)	61 (30.8%)	74 (37.4%)	3.64
Community members are well sensitized about the health services in Mbarara City	25 (12.6%)	36 (18.2%)	11 (5.6%)	52 (26.3%)	74 (37.4%)	3.58
Community members contribute to labor and local materials during health project implementation	–	–	–	96 (48.5%)	102 (51.5%)	4.52
Community members participate in linking the district health officials with the villagers	36 (18.2%)	41 (20.7%)	6 (3%)	53 (26.8%)	62 (31.3%)	3.32
City health officials normally use the already established patterns of community leadership	34 (17.2%)	47 (23.7%)	12 (6.1%)	62 (31.3%)	43 (21.7%)	3.17

Source: Field data (2025)

The results in Table 4.6 shows that 28 (14.1%) strongly disagreed, 33 (16.7%) disagreed, 9 (4.6%) were neutral, 61 (30.8%) agreed and 67 (33.8%) strongly agreed that Community members are part of the health team that foresees the health services in Mbarara City. The mean of 3.54 shows that of the respondents agreed with the statement. This implies that corporate status allows the city to make independent decisions regarding healthcare priorities by enabling a tailored approach that meets health care needs of community. Key Informant E supported this, stating,

“Meaningful involvement of community members in the health oversight team has significantly increased transparency and responsiveness. This active participation ensures that health services are not only better aligned with local needs but are also delivered more efficiently and equitably, fostering greater trust and ownership among residents.”

The implication is that fostering active community participation in health governance strengthens local decision-making, promotes accountability, and enhances the relevance and effectiveness of health service delivery in Mbarara City.

It was found out that 38 (19.2%) strongly disagreed, 51 (25.8%) disagreed, 8 (4%) were neutral, 45 (22.7%) agreed and 46 (23.2%) strongly agreed that the city health officials delegate community members to oversee some of their activities. The mean of 2.93 shows that of the respondents disagreed with the statement. This implies that respondents are almost evenly split in their views, with 45% disagreeing and 45.9% agreeing. The results suggest that while some community involvement in oversight exists, it may not be consistent or widespread. This highlights the need for clearer structures and increased efforts to formally involve community members in the monitoring and supervision of health-related activities to enhance transparency, ownership, and accountability. Qualitative insights from Key Informant B reinforced this, stating, *“While some community members have been delegated roles, many lack the adequate training and resources to effectively oversee health activities, limiting their ability to contribute fully.”* The implication is that without sustained investment in capacity building and empowerment programs, delegated community oversight roles may remain ineffective, thereby reducing community influence on health governance and limiting improvements in health service delivery.

The results shows that 119 (60.1%) agreed and 74 (37.4%) strongly agreed that the city health officials are friendly and skilled in doing their work. The mean of 4.35 shows that of the respondents agreed with the statement. This indicates that with representation from both genders, committees are better positioned to identify and address health issues that disproportionately affect specific groups such as maternal health or reproductive health in Mbarara City. The study suggests that the attitudes and professionalism of health workers play a crucial role in fostering community trust and encouraging the use of health services. Key Informant A supported this, stating

“Health officials’ professionalism and approachable demeanor encourage community

members to seek care and openly discuss sensitive health issues, which improves service uptake and health outcomes.”

The implication is that maintaining a skilled and community-friendly health workforce is critical for effective health service delivery, as it builds trust, encourages utilization of services, and ensures that diverse health needs are adequately met.

The results in Table 4.6 show 25 (12.6%) strongly disagreed, 32 (16.2%) disagreed, 6 (3%) were neutral, 61 (30.8%) agreed and 74 (37.4%) strongly agreed that the city health officials have links with government and private technical bureaus for maintenance and supply of spare parts and repair services. This indicates that being accountable facilitates access to funding and resources from the central government, which enhances healthcare services and infrastructure in health centers in Mbarara City.

Table 4.6 indicate that 25 (12.6%) strongly disagreed, 36 (18.2%) disagreed, 11 (5.6%) were neutral, 52 (26.3%) agreed and 74 (37.4%) strongly agreed that community members are well sensitized about the health services in Mbarara City. The mean of 3.58 shows that of the respondents agreed with the statement. This shows that assigning responsibilities to local authorities allows for decisions that are more tailored to the specific health needs and priorities of the community, improving the relevance of health services.

The results in Table 4.6 indicate that 96 (48.5%) agreed and 102 (51.5%) strongly agreed that the community members contribute to labor and local materials during health project implementation. The mean of 4.52 shows that of the respondents agreed with the statement. This indicates that a culture of accountability can deter corrupt practices and ensure that funds are used for their intended purposes, leading to more effective health facility operations in Mbarara City.

It was found Table 4.6 that 36 (18.2%) strongly disagreed, 41 (20.7%) disagreed, 6 (3%) were neutral, 53 (26.8%) agreed and 62 (31.3%) strongly agreed that Community members participate in linking the district health officials with the villagers. The mean of 3.32 shows that of the responses were in agreement with the statement. This implies that a majority of respondents (58.1%) believe that community members play an active role in facilitating communication and coordination between health officials and the local population. This positive perception suggests the existence of community structures or representatives that help bridge the gap between health authorities and villagers, which is vital for effective

service delivery, information flow, and community engagement. Qualitative insights from Key Informant G emphasized this, stating,

“Community members act as vital bridges between district officials and villagers, facilitating communication and ensuring that local concerns reach decision-makers. However, the effectiveness of this link depends on how empowered and supported these community representatives are.”

The implication is that strengthening the capacity and support systems for community liaisons can enhance the flow of information and responsiveness of health services, fostering more inclusive and effective healthcare delivery in Mbarara City.

The results also indicate that 34(17.2%) strongly disagreed, 47 (23.7%) disagreed, 12 (6.1%) were neutral, 62 (31.3%) agreed and 43 (21.7%) strongly agreed that city health officials normally use the already established patterns of community leadership. The mean of 3.17 shows that of the respondents agree with the statement. This implies that a slight majority of respondents (53%) agree that health officials engage with existing community leadership structures in their operations. This suggests a degree of collaboration and respect for local governance systems, which can enhance trust, coordination, and the effectiveness of health interventions. The study indicates that clearly defined and well-communicated roles within community leadership structures are essential for effective participation in health service delivery. Qualitative insights from Key Informant B highlighted this, stating,

“Leveraging existing community leadership structures has been helpful, but often these roles are not clearly defined or communicated, which leads to confusion and overlaps in responsibilities.”

The implication is that clearly defining and communicating the roles of community leaders within health service delivery is essential to enhance accountability, streamline coordination, and improve overall effectiveness of health programs in Mbarara City.

4.7 Correlation analysis between Community participation in implementation and Health service delivery

The second objective was to establish whether there was an influence between Community participation in implementation and Health service delivery, a correlation analysis was carried out. The results are presented in Table 4.7.

Table 4. 7 Correlation analysis results between Community participation in implementation and health service delivery

		Community participation in implementation	Health service delivery.
Community participation in implementation	Pearson Correlation	1	.782 ^{**}
	Sig. (2-tailed)		.005
	N	198	198
Health service delivery	Pearson Correlation	.782 ^{**}	1
	Sig. (2-tailed)	.005	
	N	198	198

^{**}. Correlation is significant at the 0.01 level (2-tailed).

Table 4.7 presents the results of a Pearson Correlation analysis between Community participation in implementation and health service delivery. The Pearson correlation coefficient (r) is 0.782 which indicates a strong positive relationship between Community participation in implementation and the health service delivery. This means that as community participation in implementation increases, the health service delivery also tends to increase significantly, and the reverse is true.

The significance (sig.= .005) or P-value is less than the standard threshold of 0.05 meaning that the relationship is statistically significant and this suggests that the relationship between Community participation in planning and the quality of health services are not due to chance.

Based on the statistical analysis above the hypothesis that there is a relationship between Community participation in implementation and Health service Delivery is supported as the results indicate a strong positive and statistically significant relationship between these two variables. The findings support the notion that Community participation in implementation improves the standard of Health service Delivery in Mbarara City in a substantial and statistically significant way (r = 0.782, p = 0.005). Consequently, the alternative hypothesis is accepted and validated.

Qualitative insights from Key Informant B strongly supported these results, stating,

“When community members are actively involved in implementing health initiatives, they take ownership and ensure better adherence to plans, which leads to more effective and sustainable health outcomes.”

The implication is that health policymakers and program implementers should prioritise mechanisms that enhance community involvement during the implementation phase to maximise the impact and sustainability of health service delivery improvements in Mbarara City.

4.8 Community participation in monitoring and evaluation, and Health service delivery.

The study aimed at determining relationship between Community participation in monitoring and evaluation, and Health service delivery in Mbarara City. Quantitative data was computed to determine means that show the average and central tendency responses in each question of Likert scale which were asked to respondents. All the variables were measured on a five-point Likert scale ranging from 1-Strongly Disagree (SD), 2 – Disagree (D), 3 – Not Sure (NS), 4 – Agree (A) and 5 - Strongly Agree (SA). A mean above 3 indicates an agreement of respondents, a mean of 3 shows agreement and a mean below 3 shows disagreement by respondents. The standard deviation (Std) of close to 1 show agreement, while the standard deviation of close to Zero show the disagreement of the respondents. The findings were presented in Table 4.8.

Table 4. 8 Descriptive statistics for community participation in monitoring and evaluation, and Health service delivery.

Community participation in monitoring and evaluation	SD	D	NS	A	SA	Mean
The City health officials involve community members in determining whether the project objectives were achieved.	07 (3.5%)	05 (2.5%)	02 (1%)	88 (44.4%)	96 (48.5%)	4.32
The city health officials ensure that all their activities are done in conformity with the law.	97 (48.9%)	72 (36.4%)	6 (3%)	12 (6.1%)	11 (5.6%)	1.83
Community members are always asked if the health services meet their expectations	–	–	–	107 (54.1%)	91 (45.9%)	4.46
The city health officials always give timely communication to communities about any changes	26 (13.1%)	32 (16.2%)	–	74 (37.4%)	66 (33.3%)	3.62
The district health officials involve all community members in comparing the planned works with actual results	11 (5.6%)	18 (9.1%)	5 (2.5%)	78 (39.4%)	86 (43.4%)	4.06
Assessment of performance is done as a teamwork exercise by both community members and city health officials	15 (7.6%)	25 (12.6%)	6 (3%)	69 (34.8%)	83 (41.9%)	3.91
The annual performance reports are disseminated to all community members using many forums	78 (39.4%)	65 (32.8%)	4 (2%)	25 (12.6%)	26 (13.1%)	2.27

Source: Field data (2025)

The results in Table 4.8 shows that 7 (3.5%) strongly disagreed, 5 (2.5%) disagreed, 2 (1%) were neutral, 88 (44.4%) agreed and 96 (48.5%) strongly agreed that city health officials involve community members in determining whether the project objectives were achieved. The mean of 4.32 shows that of the respondents agreed with the statement. This implies that an overwhelming majority of respondents (92.9%) perceive that community members are actively involved in evaluating the success of health projects. This high level of agreement reflects a strong participatory approach in project monitoring and evaluation, which can

enhance accountability, foster community ownership, and ensure that interventions remain responsive to local needs.

Qualitative insights from Key Informant H reinforced this finding, stating,

“Community involvement in evaluating health projects has improved accountability and transparency. When residents participate in assessing outcomes, it fosters a sense of ownership and motivates better project performance.”

The implication is that incorporating community members in project evaluation processes strengthens oversight, enhances trust in health initiatives, and contributes to more sustainable and effective health service delivery in Mbarara City.

Table 4.8 indicate that 97 (48.9%) strongly disagreed, 72 (36.4%) disagreed, 6 (3%) were neutral, 12 (6.1%) agreed and 11 (5.6%) strongly agreed that the city health officials ensure that all their activities are done in conformity with the law. This implies that a significant majority of respondents (85.3%) perceive that health officials do not consistently comply with legal requirements in their activities. This perception raises concerns about governance, accountability, and adherence to regulations within the city’s health sector, highlighting a need for stronger oversight and enforcement to ensure that health interventions are conducted legally and ethically. Qualitative insights from Key Informant C highlighted this concern, stating, *“There are frequent lapses in adherence to legal and regulatory frameworks, which undermines the legitimacy of health programs and leads to mistrust among community members.”* The implication is that failure to consistently operate within legal guidelines compromises the integrity and effectiveness of health services, reducing community confidence and potentially exposing the health system to legal and ethical risks in Mbarara City.

It was found out that 12 (6.1%) agreed and 11 (5.6%) strongly agreed that Community members are always asked if the health services meet their expectations. The mean of 4.46 shows that of the respondents agreed with the statement. This low level of agreement suggests that community feedback on health services is rarely sought. Therefore, opportunities to improve service quality based on community input may be limited, potentially affecting satisfaction and service effectiveness. Qualitative insights from Key Informant H reinforced this finding, stating, *“Community involvement in evaluating health projects has improved accountability and transparency. When residents participate in assessing outcomes, it fosters*

a sense of ownership and motivates better project performance.” The implication is that incorporating community members in project evaluation processes strengthens oversight, enhances trust in health initiatives, and contributes to more sustainable and effective health service delivery in Mbarara City.

The results indicate that 26 (13.1%) strongly disagreed, 32 (16.2%) disagreed, 74 (37.4%) agreed and 66 (33.3%) strongly agreed that the city health officials always give timely communication to communities about any changes. The mean of 3.62 shows that of the respondents agreed with the statement. The mean of 3.62 shows that the majority of respondents agree with the statement. This implies that most community members perceive that health officials generally provide timely updates about changes, reflecting a moderately positive level of communication. However, the combined disagreement of 29.3% suggests there is still room for improvement to ensure more consistent and widespread timely communication across all community groups. Qualitative insights from Key Informant E supported this finding, stating, *“Timely communication has improved noticeably, with health officials using local meetings and radio to keep communities informed, which helps residents prepare and respond better to health changes.”* The implication is that consistent and timely communication fosters trust, enhances community preparedness, and supports more effective health service delivery in Mbarara City.

The Table 4.8 indicates that 11 (5.6%) strongly disagreed, 18 (9.1%) disagreed, 5 (2.5%) were neutral, 78 (39.4%) agreed and 86 (43.4%) strongly agreed that the district health officials involve all community members in comparing the planned works with actual results. The mean of 4.06 shows that of the respondents agreed with the statement. This implies that community members are generally perceived to be actively involved in monitoring and evaluating health projects, fostering transparency and accountability in the implementation process. Such involvement likely enhances community ownership and ensures that health interventions are aligned with local expectations and needs. Qualitative insights from Key Informant F supported this, stating, *“Engaging community members in reviewing health project outcomes ensures transparency and accountability, and it allows for timely adjustments to improve future interventions.”* The implication is that inclusive evaluation processes strengthen community trust and contribute to more responsive and effective health service delivery in Mbarara City.

The results in Table 4.8 also shows that 15 (7.6%) strongly disagreed, 25 (12.6%) disagreed, 6

(3%) were neutral, 69 (34.8%) agreed and 83 (41.9%) strongly agreed that assessment of performance is done as a teamwork exercise by both community members and city health officials. The mean of 3.91 shows that of the respondents agreed with the statement. This implies a positive perception that performance assessments are collaborative efforts, involving both health officials and community members, which can enhance mutual accountability, shared responsibility, and more effective health service delivery. Qualitative insights from Key Informant A supported this finding, stating, *“Collaborative performance assessments between health officials and community members have fostered mutual understanding and allowed for more comprehensive evaluations that consider both service delivery and user experience.”* The implication is that fostering teamwork in performance assessments enhances transparency, improves service quality, and strengthens the partnership between health providers and the community, leading to more effective health service delivery in Mbarara City.

It was discovered that 78 (39.4%) strongly disagreed, 65 (32.8%) disagreed, 4 (2%) were neutral, 25 (12.6%) agreed and 26 (13.1%) strongly agreed that the annual performance reports are disseminated to all community members using many forums. The mean of 2.27 shows that of the respondents disagreed with the statement. This implies that the dissemination of annual performance reports to the community is perceived as inadequate or limited, suggesting a gap in transparency and communication. Such a shortfall may hinder community awareness, participation, and trust in health sector accountability processes, highlighting the need for improved and more inclusive information-sharing mechanisms. Qualitative insights from Key Informant B highlighted this challenge, stating, *“Performance reports are often shared in limited forums and rarely reach the broader community, which restricts transparency and reduces opportunities for community feedback.”* The implication is that inadequate dissemination of performance reports limits community awareness and engagement, weakening accountability mechanisms and ultimately hindering improvements in health service delivery in Mbarara City.

4.9 Correlation analysis between Community participation in monitoring and evaluation, and Health service delivery

To establish whether there is an influence of Community participation in monitoring and evaluation and Health service delivery, a correlation analysis was carried out and results are presented in Table 4.9.

Table 4. 9 Correlation analysis between Community participation in monitoring and evaluation and health service delivery

		Community participation in monitoring and evaluation	Health service delivery
Community participation in monitoring and evaluation	Pearson	1	.607**
	Correlation		
	Sig. (2-tailed)		.000
	N	198	198
Health service delivery	Pearson	.607**	1
	Correlation		
	Sig. (2-tailed)	.000	
	N	198	198

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

The results in Table 4.9 show the correlation analysis results between Community participation in monitoring and evaluation and Health service delivery. The Pearson correlation coefficient ($r = 0.607$) indicates a moderate positive relationship between Community participation in monitoring and evaluation and the Health service delivery. This suggests that as Community participation in monitoring and evaluation improves, there is a moderate increase in the quality of health service delivery. The p-value on the other hand is 0.000, which is below the significance level of 0.01. This means the relationship is statistically significant and is not likely to have occurred by chance. The findings demonstrate that the Health service delivery in Mbarara City is positively impacted by community participation in monitoring and evaluation in a moderate and statistically significant way ($r = 0.607$, $p = 0.000$). Consequently, the null hypothesis is disproved and the hypothesis is validated.

4.10 Linear regression

The regression analysis was used to establish the role of community participation on Health service delivery. Furthermore, based on the regression results, the study hypotheses were answered. The results are presented in the Table 4.10.

Table 4. 10 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.686 ^a	.579	.506	.74858

a. Predictors: (Constant), Planning, implementation, Monitoring and evaluation

The results in Table 4.10 shows that adjusted R Square value of 0.506 adjusts the R² value for the number of predictors in the model. This means that even after accounting for the number of variables, about 50.6% of the variance in health service delivery is still explained by the community participation. The adjusted R² is useful for determining how well the model generalizes to other samples. From the above it can be concluded that the model suggests a strong positive relationship between the community participation (Planning, implementation, Monitoring and evaluation) and the health service delivery and that 57.9% of the variation in health service delivery can be explained by the community participation, which is a good indication that these factors significantly influence health care quality. The Adjusted R² of 0.506 confirms that the model remains strong even when adjusted for the number of predictors.

Table 4. 11 ANOVA

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	19.064	3	6.355	11.340	.000 ^b
	Residual	108.712	195	.560		
	Total	127.776	198			

a. Dependent Variable: Health service delivery

b. Predictors: (Constant), Planning, implementation, Monitoring and evaluation

The Significance (Sig.) which is the p-value (.000) indicates that the model is statistically significant. Since the p-value is less than 0.05, we reject the null hypothesis and conclude that at least one of the predictors (Planning, implementation, Monitoring and evaluation) significantly affects the health service delivery. In summary, the regression model significantly explains the variation in the health service delivery based on community participation in Planning, Implementation, Monitoring and evaluation.

Table 4. 12 Multiple regression coefficients

Coefficients ^a						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.300	.274		4.744	.000
	Planning	.242	.123	.145	1.971	.000
	Implementation	.103	.100	.073	1.021	.002
	Monitoring and evaluation	.376	.099	.275	3.793	.000
a. Dependent Variable: Health service delivery						

The results in the above Table 4.12 indicate that beta regression coefficient for planning= 0.145 at P-value=0.00<0.05; beta regression coefficient for implementation =0.073 at p-value 0.002 > 0.05 and regression coefficient for M&E =0.275 at p-value = 0.00 < 0.05. This shows that planning, implementation and M&E have a statistically significant influence on Health service delivery.

The results imply that that a unit increase in community participation in planning leads to 0.145 unit increases in Health service delivery making which is statistically significant at 95% level of significance since p-value (0.000) is less than to 0.05; hence hypothesis one that states “*Community participation in planning has a significant influence on Health service delivery*” was accepted.

On community participation in implementation, the regression coefficient for community participation in implementation =0.073 at p-value $0.002 < 0.05$ shows that community participation in implementation has a positive but a significant effect on Health service delivery. This implies that a unit increase in community participation in implementation will lead to an increase in Health service delivery by 0.073 units. However, this effect is statistically significant at 95% level of significance and p-value (0.002) which is less than 0.05. This means that hypothesis two which states that “*Community participation in implementation have a significant influence on Health service delivery*” was accepted.

On Community participation in monitoring and evaluation, the regression coefficient shows that a unit increase in Community participation in monitoring and evaluation will lead to 0.275 increases in Health service delivery and this is significant at 95% level of significance since p-value (0.000) is less than 0.05. Hence, the hypothesis that “*Community participation in monitoring and evaluation has a significant influence on Health service delivery*” is accepted. By implication, Community participation in monitoring and evaluation was are likely to increase Health service delivery in Mbarara City.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, DISCUSSION AND RECOMMENDATION

5.1 Introduction

This chapter presents the discussion of key findings, conclusion drawn from the findings highlighted and recommendation made there-to. The conclusions and recommendations drawn are in quest of addressing the purpose of this study which was to examine how community participation affects Health service delivery in Mbarara City.

5.2 Summary of the findings

5.2.1 Community participation in Planning on Health Service Delivery

The study found out that there is a positive weak significant relationship between community participation in planning on Health service delivery ($r = 0.469$, $p = 0.000 < 0.05$). The study also found out that a unit increase in community participation in planning will lead to 0.145 unit increase on Health service delivery making it statistically significant at 95% level of significance. Since p-value (0.000) is less than 0.05; the hypothesis that states that “community participation in Planning has a significant influence on Health service delivery” was accepted.

Qualitatively, Community participation in planning has a direct and significant impact on the effectiveness of health service delivery. When community members are actively involved in identifying priorities, contributing to decision-making, and suggesting needed resources, health projects are more likely to address actual local needs, enhancing relevance and utilization. The qualitative findings indicate that participatory planning reduces resource wastage, ensures appropriate allocation of equipment and supplies, and fosters a sense of ownership among residents. In contrast, limited involvement at the planning stage leads to misaligned priorities, low acceptance of interventions, and reduced effectiveness of health initiatives. Therefore, engaging communities in the planning process strengthens responsiveness, accountability, and overall service delivery outcomes by aligning health interventions with the real needs and expectations of the population.

5.2.2 Community participation in implementation on Health Service Delivery

The study found out that there is a positive strong significant influence of community participation in implementation on health service delivery ($r = 0.782$, $p = 0.002 < 0.05$). The study also found out that community participation in Planning has a positive but an

insignificant effect on Health service delivery. The regression coefficient for community participation in implementation =0.073 at p-value 0.308 > 0.05 show that implementation have a positive but a significant effect on Health service delivery. This implies that a unit increase in community participation in implementation will lead to an increase in Health service delivery.

Qualitatively, the qualitative findings indicate that community participation in the implementation of health service delivery in Mbarara City. Active involvement of community members in health oversight promotes transparency, accountability, and alignment of services with local needs, fostering trust, ownership, and equitable access. However, the effectiveness of participation depends on adequate training, resources, and empowerment, as unprepared community members may struggle to contribute meaningfully. Community representatives serve as critical bridges between officials and residents, facilitating timely communication and responsiveness, while the professionalism and approachability of health officials further encourage engagement and service uptake. Conversely, unclear roles, overlapping responsibilities, and insufficient support for community leaders can hinder implementation efforts. Overall, the findings suggest that structured, well-supported, and clearly defined community involvement in health service implementation improves coordination, responsiveness, and the overall relevance and effectiveness of healthcare delivery.

5.2.3 Community participation in monitoring and evaluation on Health Service Delivery

The study found out that there is a positive moderate significant influence of community participation in monitoring and evaluation on Health service delivery ($r = 0.607$, $p < 0.007$). The regression coefficient shows that a unit increase in community participation in monitoring and evaluation will lead to 0.275 increase in Health service delivery and this is significant at 95% level of significance since p-value (0.00) is less than 0.05. Hence, the hypothesis “*Community participation in monitoring and evaluation has a significant influence on Health service delivery*” is accepted. By implication, community participation in monitoring and evaluation is likely to increase Health service delivery.

Qualitatively, the qualitative findings indicate that community representatives act as vital communication bridges between officials and residents, enabling timely reporting of local concerns and facilitating coordinated responses. However, the effectiveness of participation depends on adequate training, resources, and clearly defined roles; without these, community contributions may be limited, leading to overlaps, confusion, and reduced impact.

Additionally, a professional and approachable health workforce enhances community engagement, encouraging service utilization and addressing diverse health needs. Overall, structured and well-supported community participation in implementation strengthens coordination, responsiveness, and the overall relevance and effectiveness of health service delivery.

5.3 Discussion

5.3.1 Community participation in Planning on Health Service Delivery

The study found out that there is a positive weak significant relationship between planning on Health service delivery ($r = 0.469$, $p = 0.000 < 0.05$). The study also found out that a unit increase in community participation in planning will lead to 0.145 unit increases in Health service delivery making which is statistically significant at 95% level of significance since p-value (0.050) is equal to 0.05; hence hypothesis one that states “*community participation in Planning has a significant influence on Health service delivery*” was accepted.

The study is in line with Atwijukire, Kyohairwe and Kiwanuka (2015) who propounded that community participation in planning creates a sense of ownership among clients which enables them to work tirelessly to ensure good health service delivery. Participation fosters transparency and accountability. When community members have a say in decision-making processes, they are more likely to hold organizations accountable and ensure that resources are used effectively (Shields et al., 2021).

The study is in line with Nyabera (2015) participation of community in planning is vital for the smooth implementation of health projects and lack of their participation in planning may affect Health Service Delivery. This implies that when community are involved in planning, they will clearly understand the expected deliverables within a specified cost, time frame, scope and deliverables based on quality standards. In health centers where the community is never involved in planning activities, such as coming up with the cost of activities, and where in-charges assume that their clients have nothing to do with cost later affect the service delivery.

The study is in agreement with Adewale and Esther (2022) who revealed that community s’ involvement in the strategic planning has a positive significant effect on service delivery on the effect of community s’ involvement in the strategic planning on service delivery in the

University of Venda and to determine how different community s are involved in the strategic planning.

The study is in agreement with Okot, Basheka and Kweyamba (2011) who conducted the study on the influence of community's' participation on quality service delivery in Case Med Care, a medical scheme owned and managed by Case Medical Hospital in Kampala. The findings revealed that the overall community especially in planning had a positive influence on quality of healthcare.

The study is in agreement with Kugonza and Mukobi (2025) who studied how community participation in local planning affects service delivery in Buikwe District local government, the results found that overall community' participation in planning local government projects positively influenced service delivery by 42% respectively based on Pearson Correlation Coefficient. The study further found that information is not readily accessible or effectively disseminated to the majority of citizens and therefore is not fully harnessed for planning, monitoring and evaluating government projects.

5.3.2 Community participation in implementation on health service delivery

The study found out that there is a positive strong significant influence community participation in implementation on health service delivery ($r = 0.782$, $p=0.005<0.05$). The study also found out community participation in Planning have a positive but an insignificant effect on Health service delivery. The regression coefficient for community participation in implementation $=0.073$ at $p\text{-value } 0.308 > 0.05$ show that implementation have a positive but a significant effect on Health service delivery. This implies that a unit increase in community participation in implementation will lead to an increase Health service delivery.

The study is in line with Mphako (2013) studied public participation and service delivery: citizen participation in implementing infrastructural programs in Ingquza Hill Municipality in South Africa which is concerned with the interaction between communities and government in the exercise of providing services, revealed that public participation in implementation of infrastructural programs in the Ingquza Hill Municipality strongly enhanced the delivery of services. Stumbraitė-Vilkišienė (2012) on the study about citizen participation in the local public service provision and quality improvement in Municipalities of the Republic of Lithuania revealed that citizens involvement in the project implementation process not only

because of good governance but also in order to receive input for increasing the quality of local policies and quality of services.

The study is in line with Le, Vu, Hens and Van Heur (2024) who studied community participation in the implementation of the environmental management system (EMS) to tackle environmental issues and ensure compliance with regulations, three ports in Vietnam and two ports in Cambodia. The findings show that while ports are perceived as sources of environmental problems, they are also seen as important economic powerhouses since involving the port community s in implementation of the system would make it much easier for them to access its services.

The study is in agreement with Mehlape (2022) who noted that the presence of the community or their elected representatives on project steering committees or boards or other supervisory or decision-making bodies empowers the community to play an active role in project implementation. Also, technical training and assistance to build the community's capacity for organizational and technical responsibilities during project implementation contribute to community's empowerment and improves chances for project sustainability once the technical and managerial assistance is withdrawn.

The study is in agreement with Mnqayi (2021) who noted that involvement of people in implementation and the utilization of local resources generate a sense of ownership over the development interventions by the local people thereby promoting sustainability of the project. Identification of key community leaders is a part of the project implementation process, and consists of assigning individuals and groups who are affected by the project or use it. Adequate and appropriate strategies can then be designed and implemented to enhance the positive influence of community participation in sustainability. This becomes a fundamental risk management issue for project managers and failing to establish a comprehensive connection between risks related to project and community participation will lead likely to project failure (Mehlape, 2022). It is therefore very important for the community leaders to be involved in the implementation of projects because this will help in service delivery.

The study is in agreement with Mnqayi (2021) who revealed that performance of development project is largely depending on the attitudes of different community members. Hence, during the implementation, if key community members are not committed to adequately execute their responsibilities, it will adversely impact the overall project performance and sustainability. Mnqayi (2021) continued that the stakeholder's participation

like community is highly important to project success, and therefore taking account their claims and interests during the project implementation stages is largely required to achieve project objectives and sustainability.

5.3.3 Community participation in monitoring and evaluation on health service delivery

The study found out that there is a positive moderate significant influence of community participation in monitoring and evaluation on Health service delivery ($r = 0.607$, $p < 0.007$). The regression coefficient shows that a unit increase in community participation in monitoring and evaluation will lead to 0.275 increase in Health service delivery and this is significant at 95% level of significance since p-value (0.00) is less than 0.05. Hence, the hypothesis “*Community participation in monitoring and evaluation has a significant influence on Health service delivery*” is accepted. By implication, community participation in monitoring and evaluation is likely to increase Health service delivery.

The study is in agreement with Nyabera (2015) who conducted a study on influence of stakeholder participation on implementation of projects in Kenya in Compassion International Assisted Projects in Mwingi Sub-County and found out that there is there is a strong relationship between community participation in monitoring and evaluation and service delivery. To ensure service delivery, community must be involved in monitoring activities such as knowing the schedules, which activities are to be executed, when, where, which resources are required, what are the objectives (scope), how much time is needed and knowing whether the standard operating procedures are available to ensure delivery of quality outputs. Community is vital in giving feedback about the project activities and services which enables members understand whether the activities are on track of achieving its set objectives and targets based on the community’s feedback which might be negative or positive feedback.

The study is in agreement with Kananura et al. (2017) who studied community participation in monitoring and evaluation and Health service delivery focusing maternal and newborn babies’ department in eastern Uganda hospitals. The results revealed that Community participation in M&E eased service delivery by identifying emerging issues, such as weak implementation by some village health teams, health facility constraints such as poor use of standard guidelines, lack of placenta disposal pits, inadequate fuel for the ambulance at some facilities, and poor care for low birth weight infants. As a result, the sub-county leadership

constructed placenta disposal pits, the district health officer provided fuel for ambulances, and health workers received refresher training and mentorship on how to care for newborns.

The study is in agreement with Kwenia and Moronge (2015) who asserted that providing an environment where communities participate freely, improves their knowledge and perception about the project subsequently contributing to service delivery. Community participation in monitoring and evaluation is beneficial to a project's efficiency and sustainability. To this end, there has been increased attention on participatory monitoring and evaluation in projects including rural water supplies (United Nations, 2017). Participatory monitoring and evaluation in project life cycle management is thus proposed as a pathway to sustainability (Sulemana et al., 2018).

The study is in agreement with United Nations Report (2017) who noted that community participation in Monitoring and Evaluation is critical in project sustainability since it offers new ways of assessing and learning from change that are more inclusive and more responsive to the needs and aspirations of those most directly affected.

The study is in agreement with Jha et al. (2019) who indicated that those projects managed by the community had a better performance compared to those operated by the local government. Likewise, Muniru, Gakuu and Rambo (2017) elaborate that enhanced sustainability in rural areas is attainable by ensuring that projects meant to serve the community are managed by the community members. The empirical contributions from these scholars thus affirm the impact of community participating in monitoring and evaluation contributes to service delivery.

5.4 Conclusion

5.4.1 Community participation in planning on Health service delivery

The study concluded that there is a positive weak significant relationship between community participation in planning on Health service delivery. The study also concluded that, a unit increase in community participation in planning will lead to 0.145 unit increase in Health service delivery making it statistically significant at 95% level of significance. Since p-value is (0.0500) which is less than 0.05, the hypothesis that states "*Planning has a significant influence on Health service delivery*" was accepted.

In conclusion, qualitative findings demonstrate that active community participation in the

planning of health service delivery enhances the relevance, utilization, and effectiveness of interventions. Engaging residents in identifying priorities and decision-making ensures appropriate resource allocation, fosters ownership, and strengthens accountability, while limited involvement results in misaligned priorities and reduced service impact. This is in support of both Representative Democracy and Stakeholder theories. Therefore, integrating community voices in planning is essential for responsive and effective health service delivery.

5.4.2 Community participation in implementation on health service delivery

The study concluded that there is a positive strong significant influence of community participation in implementation on health service delivery. The study also concluded that implementation has a positive but insignificant effect on Health service delivery. The regression coefficient for community participation in implementation is 0.073 with a p-value of 0.002 which is less than 0.05. This shows that implementation has a positive and significant effect on Health service delivery. This implies that a unit increase in community participation in implementation will lead to an increase in Health service Delivery.

The study concluded that that well-structured and supported community participation in implementation strengthens transparency, accountability, and responsiveness, ensuring services align with local needs. This is in support of both Representative Democracy and Stakeholder theories. Adequate training, clear roles, and empowered community representatives are crucial for effective engagement, ultimately enhancing trust, utilization, and the overall quality of healthcare delivery in Mbarara City.

5.4.3 Community participation in monitoring and evaluation on health service delivery

The study concluded that there is a positive moderate significant influence of community participation in monitoring and evaluation on health service delivery. The study also concluded that a unit increase in community participation in monitoring and evaluation will lead to 0.275 increase in Health service delivery and this is significant at 95% level of significance since p-value (0.00) is less than 0.05.

The findings underscore that structured and well-supported community participation in health service implementation enhances transparency, accountability, and responsiveness, ensuring services meet local needs. This is in support of both Representative Democracy and Stakeholder theories. Effective engagement, supported by training, clear roles, and a

professional health workforce, strengthens coordination, trust, and overall quality of healthcare delivery in Mbarara City.

5.5 Recommendations.

5.5.1 Community participation in Planning on health service delivery

Community participation in planning has a positive, albeit weak significant effect on health service delivery. Health authorities and local governments should actively involve communities in health service planning. This can include establishing health planning committees at the village or parish level, conducting regular community needs assessments, and facilitating workshops that allow community members to voice priorities and suggestions for health programs. Strengthening participation at this stage, can gradually increase its impact on service quality.

5.5.2 Community participation in implementation on health service delivery

The study found out that community participation in implementation had a positive but statistically insignificant effect. Increasing structured involvement of communities in the implementation of health programs could yield better outcomes. Health facilities should create volunteer health committees or task forces to support activities such as outreach campaigns, vaccination drives, and sanitation initiatives. Proper training and support for these community members can make implementation efforts more effective and impactful.

5.5.3 Community participation in monitoring and Evaluation on health service delivery

Given the moderate and significant influence of community participation in monitoring and evaluation, health systems should formalize community roles in assessing Health Service Delivery. This can include establishing feedback channels, community scorecards, and participatory evaluation meetings where local residents review health service performance. By actively involving the community in monitoring and evaluation, accountability is increased, and health service quality can improve significantly.

5.6 Contribution to the body of knowledge

The purpose of the study was to examine how community participation affects Health Service delivery in Mbarara City. The study findings can have some noticeable inference and contribute to thoughtful appreciation of relationship between community participation and quality of Health Service Delivery in Mbarara City. Critical analysis of community participation attest to the fact that planning, implementation, monitoring and evaluation have

profound relationship on Health Care Services if properly planned, implemented and continuously monitored and reviewed. This study too has supplemented to the many other contributors on the importance of community participation and Health Service Delivery thus an effective community participation would translate into an ideal quality Health service Delivery not only in Mbarara City but in many institutions.

5.7 Areas for further Research

- i. Relationship between community participation and measurable health outcomes.
- ii. Sustainability of Participatory Approaches and health service delivery.
- iii. Socio-cultural, economic, political, and institutional barriers among health sector.

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APPENDICES

Appendix A: Questionnaire

Dear Sir/Madam,

I am a student at Bishop Stuart University conducting a survey to establish the contribution of community participation on Health Service Delivery in Uganda specifically Mbarara City. This research forms part of my Master's degree in public, administration and management. Your participation in this study by completing the questionnaire is highly valued. Please be assured that the information collected was used solely for academic purposes and was handled with utmost confidentiality.

Section A: Background Variables: Classification of Respondents

Please provide accurate information about yourself. Kindly select the most appropriate option by ticking (✓) the box. the best alternative that fits your opinion.

1. Age of respondent

- 1. 18-30 years ☐
- 2. 31-40 years ☐
- 3. 41-50 years ☐
- 4. Above 50 years. ☐

2. Sex of respondent

- 1. Male ☐
- 2. Female ☐

4. Academic qualification

- 1. Secondary education ☐
- 2. Bachelor's degree ☐
- 3. Post graduate diploma ☐
- 4. Masters ☐
- 5. Others (specify).....

5. Period having services with Health Centre

- 1. Below five years ☐
- 2. Between five and ten years ☐
- 3. Over ten years ☐

Section B; Community Participation in Planning

Please express your agreement or disagreement with the following statements regarding your workplace using the provided scales: 5 - Strongly Agree, 4 - Agree, 3 - Not Sure, 2 - Disagree, 1 - Strongly Disagree.

Statements	1	2	3	4	5
Community members are always consulted by city health officials before health projects are started					
Community members help in identifying all possible disease out breaks and other needs related					
The health services given to communities base on their identified needs					
Mbarara City requests community members to compile a list of health resources needed in advance					
The city health officials schedule meetings with community members to discuss the health requests and their objectives					
The city health officials inform different groups about the sources of income for health related projects					
The city health officials inform community members of the necessary expenditures related to health					
Community members participate in writing the health project proposals in city					
Community members give recommendation before some health services are extended to homes					
Community members are involved in either signing or preparing the financial documents related to health services in this city					

Section C: Community Participation in Implementation

Please express your agreement or disagreement with the following statements regarding your workplace using the provided scales: 5 - Strongly Agree, 4 - Agree, 3 - Not Sure, 2 - Disagree, 1 - Strongly Disagree.

Statements	1	2	3	4	5
Community members are part of the health team that foresees the health services in Mbarara City					
The district health officials delegate community members to oversee some of their activities					
The health project beneficiaries help to ensure efficient utilization of health services					
The city health officials have links with government and private technical bureaus for maintenance and supply of spare parts and repair services					
The district health officials involve community members in protecting the health facilities and equipment					
The district health officials are friendly and skilled in doing their work					
Community members are well sensitized about the health services in Mbarara City					
Community members contribute to labor and local materials during health project implementation					
Community members participate in linking the district health officials with the villagers					
City health officials normally use the already established patterns of community leadership					

Section D; Community Participation in Monitoring and Evaluation

Please express your agreement or disagreement with the following statements regarding your workplace using the provided scales: 5 - Strongly Agree, 4 - Agree, 3 - Not Sure, 2 - Disagree, 1 - Strongly Disagree.

Statements	1	2	3	4	5
The City health officials involve community members in determining whether the project objectives were achieved					
The city health officials involve community members in evaluation of risks accruing from the established project					
The city health officials ensure that all their activities are done in conformity with the law					
Community members are always asked if the health services meet their expectations					
There is a toll free telephone numbers to call for any health emergencies					
The city health officials always give timely communication to communities about any changes					
Conflicts are resolved jointly by the district health officials and community members					
Assessment of performance is done as a teamwork exercise by both community members and district health officials					
The district health officials involve all community members in comparing the planned works with actual results					
The annual performance reports are disseminated to all community members using many forums					

Section E: Health service Delivery

Please express your agreement or disagreement with the following statements regarding your workplace using the provided scales: 5 - Strongly Agree, 4 - Agree, 3 - Not Sure, 2 - Disagree, 1 - Strongly Disagree.

Statements	1	2	3	4	5
Mbarara City health officials ensure good sanitation both in health centres and in communities					
Mbarara City health officials sensitize communities on good nutrition habits					
The district health officials do regular voluntary immunization in communities					
Mbarara City has a surveillance team that inspects the health stature of each family door to door					
The city health officials announce quarantine in case of outbreaks					
The city health officials have reduced maternal mortality rates					
The city health officials have reduced infant mortality rates					
The city health officials have reduced patient mortality rates					
The health centers in this city have enough housing for both patients and staff					
The health centers in this city have enough beds for admitting patients					
The health centers in this city have essential drugs					
The health centers in this district have enough staff					
The health centers in this district have a well-equipped laboratory					
The health centers in this city have equipment for dealing with emergency					
The health centers in this city have adequate sanitation and hygiene equipment					

Thank you for participation

Appendix A: Interview guide

Dear Sir/Madam;

I am a student at Bishop Stuart University conducting a survey to establish the contribution of community participation on Health Service Delivery in Uganda specifically Mbarara City. This research forms part of my Master's degree in public, administration and management. Your participation in this study by completing the questionnaire is highly valued. Please be assured that the information collected was used solely for academic purposes and was handled with utmost confidentiality.

Questions

- 1 How much time have you spent working in this health Centre?
- 2 How do you involve community members in planning? *Probe evidence.*
- 3 How do you involve community members in implementation of health programs?
Probe evidence.
- 4 How do you involve community members in monitoring and evaluation of health programs? *Probe evidence*
- 5 (a) How do you ensure quality health service delivery?
(b) What are the indicators of good quality health service delivery in this health Centre?