

**THE ROLE OF HEALTH UNIT MANAGEMENT COMMITTEES ON HEALTH
SERVICE DELIVERY IN HEALTH CENTRE IIIS; A CASE OF SHEEMA
MUNICIPALITY, UGANDA**

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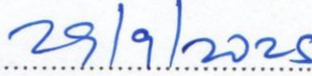
**A DISSERTATION SUBMITTED TO THE DIRECTORATE OF GRADUATE STUDIES
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DECLARATION

I Bwebare Wycliffe, do hereby declare that the work contained in this dissertation titled "**The role of Health Unit Management Committees on Health Service Delivery in Health Centre IIIIs: A Case of Sheema Municipality, Uganda**" is my original work and has never been submitted to any other University or institution for any award.

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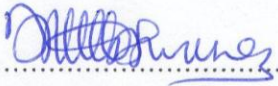
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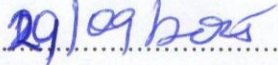
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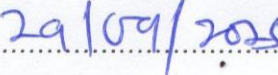
APPROVAL

This dissertation about **“The role of Health Unit Management Committees on Health Service Delivery in Health Centre IIIs: A case of Sheema Municipality, Uganda”** has been done under our supervision and is submitted for the fulfillment of with approval.

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DEDICATION

I dedicate this dissertation to my beloved wife, my children, and my parents, whose love, support, and encouragement have been a constant source of strength throughout my academic journey.

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My heartfelt appreciation goes to my wife for her continuous technical guidance and unwavering support throughout the process of writing this dissertation.

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LIST OF ACRONYMS AND ABBREVIATIONS

AKHS	-	Aga Khan Health Services
CSOs	-	Civil Society Organizations
EA-HPRO	-	The East Africa Health Policy and Research Organization
EHT	-	Environmental Health Technician
EPRC	-	Economic Policy Research Centre
ESEA	-	East and Southern Africa
FCHVs	-	Female Community Health Volunteers
HC	-	Health Centre
HC111s	-	Human center 111.
HFGCs	-	Health Facility Governing Committees
HSDP	-	Health Sector Development Plans
HUMCs	-	Health Unit Management Committees
ISER	-	Initiative for Social Economic Rights
LLGs	-	Lower Local Governments
MNCH	-	Maternal, Newborn and Child Health
MoH	-	Ministry of Health
PHC	-	Primary Health Care
PNFP	-	Private Not for Profit
RDC	-	Rural District Council

VCW	-	Village Community Health Worker
VDCs	-	Village Development Committees
VHTs	-	Village Health Teams
VHW	-	Village Health Worker
WHO	-	World Health Organization

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ABSTRACT

Countries across the World are working hard to improve health service delivery with in communities. Ensuring health lives and promoting well-being of all at all ages is the major focus of Sustainable Development Goal 3 and target 3.8 was set to achieve this goal by 2030. This study focused on examining the role of Health Unit Management Committees on Health Service delivery. Specifically, to establish the effect of health unit management committees' planning and budgeting on accessibility of quality health services; to determine the influence of health unit management committees' motivation and incentives on health service delivery; to establish the effect of health unit management committees' supervision and feedback on health service delivery in Sheema municipality, Uganda. A cross-sectional survey research design was employed, using qualitative approach. Purposive sampling technique was used to select 131 respondents. Data collection methods included questionnaire survey and interview method. Quantitative data was analyzed using descriptive analysis, Pearson correlation coefficient, multi linear regression with SPSS v.29. Qualitative data was analyzed using thematic analysis supported by NVIVO software. The study found and concluded that Health Unit Management Committees' planning significantly improves health service delivery ($r = 0.536$, $\beta = 0.451$, $p < 0.05$). The study also concluded that Health Unit Management Committees' motivation and incentives significantly enhance health service delivery ($r = 0.645$, $\beta = 0.327$, $p < 0.05$). The study further concluded that Health Unit Management Committees' supervision and feedback significantly improve health service delivery ($r = .702$, $\beta = 0.544$, $p < 0.05$). The study recommended that local governments, the Ministry of Health, and development partners should implement structured incentive schemes for HUMC members, including financial allowances, recognition, certificates, and capacity-building opportunities, to boost morale and commitment. Additionally, continuous supervision and feedback mechanisms should be institutionalized through regular visits, reporting frameworks, and timely feedback, while encouraging HUMCs to document and share their findings to improve health service delivery. Targeted training on supervision, leadership, and community engagement should further empower HUMCs to provide effective oversight and integrate their feedback into health planning, ultimately enhancing service delivery in Sheema District.

DEFINITION OF KEY TERMS

Health: A state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity. A dynamic state that involves the interaction between and individual's biological, psychological and social factors that affect their overall well-being.

Health Unit Management Committees (HUMCs): Are structures that are created at the lowest level of public health facilities to ensure that communities are empowered to play their role, take responsibility for their own health and ensure that they actively participate in the design, planning and management of health services (MoH, 2019).

Health Service Delivery: Refers to the prevention and management of disease, illness, injury and other mental impairments in individuals delivered by the health care professional through the health care system and can either be routine or emergency health services.

Primary Health Care: A whole-of –society approach to effectively organize and strengthen National Health Systems to bring services for health and well-being closer to communities.

Health Centre (HC)/Health Facility/Health Unit: Any legalized place that provides health care services, such as hospital, clinics, health centres, nursing homes and rehabilitation centres.

Health Centre III: Formed at Sub County level known as Local Council III (LCIII) with a functional Laboratory, led by a Senior Clinical Officer, who runs a general Out-patient clinic and a Maternity Ward.

Service delivery: The relationship between policy makers, service providers and consumers of those services, and encompasses both services and their supporting systems. Service delivery is a mechanism to meet the needs and aspirations of the its meant to serve (Ministry of Local Government, 2013).

Community participation: is the process which provides private individuals an opportunity to influence public decisions and has a long been a component of democratic decision making.

Social Accountability of Civil Society and Citizens: Refer to holding public officials and public service providers accountable for the provision of services including health services (Lodenstain *et al.*, 2017).

Appreciative Inquiry: is an approach to nature Organizational change which is based on positive psychology and has been used in business, health and community (Daykin *et al.*, 2005).

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter also presented the background to the study, statement of the problem, objectives of the study, research questions, justification and significance of the study, study scope and the Conceptual framework for the study. This study examined the role of Health Unit Management Committees on Health Service delivery. The independent variable was Health Unit Management Committees while the dependent variable was Health Service delivery in health Centre IIIs.

1.1 Background to Study

1.1.1 Historical Background

Globally; the global priorities to transform health service delivery began in European countries in the 1980s, with the aim of co-opting professionals into management roles, either full-time or hybrid (Kirkpatrick, 2016). Health Unit Management Committees (HUMCs) were introduced to enhance community participation and improve service delivery in health centers (Bascar, 2018). HUMCs play key roles in enhancing accountability, coverage, access, and effective utilization, especially since central governments make direct transfers of funds to health facilities (Goodman et al., 2011). For example, Nepal's Health Strategic Plan emphasizes citizen and community engagement to make health services and providers accountable. Each facility typically serves about 9,000 people and has an HMC chaired by a local political representative, with members including the health facility in-charge, community representatives, a Female Community Health Volunteer (FCHV), and at least one member of a marginalized group. HMCs meet monthly to monitor, evaluate, and plan for quality care, often using Appreciative Inquiry (AI) approaches to foster innovation and team development (Subedi et al., 2010). Globally many countries have attempted to provide interventions in health service delivery through a number of reforms such as privatization, decentralization performance management initiatives (Lutwama *et al.*, 2013).

In Africa, from the 1980s onwards, the initiative to introduce HUMCs spread to African countries, influencing the expansion of participatory health management structures (Adi, 2012).

In South Africa, HUMCs were established as participatory structures to represent community interests and promote social determinants of health, including the right to health (Mulumba et al., 2018). Zimbabwe's Ministry of Health operational guidelines define the composition, roles, and responsibilities of Health Centre Committees (HCCs), which engage in health promotion, disease prevention, community advocacy, resource mobilization, and ensuring accountability (Zimbabwe MoHCW, 2009; TARSC et al., 2014).

In East Africa especially Tanzania, Health Facility Governing Committees (HFGCs) made up of community members have become integral in decentralization and social accountability reforms. They facilitate open communication between health workers and the community through forums, surveys, and focus groups, helping providers make decisions that reflect community needs (Lieberman et al., 2022; Ludia, 2022). In Kenya, Health Unit Management Committees called Health Facility Committees (HFCs) play an active role in managing health facilities and improving service quality, particularly where they control facility-level resources (Waweru et al., 2014; Goodman & Apwora, 2011). In Uganda, HUMCs serve as a critical link between the health system, local government, and grassroots communities (MoH, 2014). They are formed at all health facility levels except Health Centre I, which is constituted by Village Health Teams (VHTs). The Ministry of Health requires that HUMCs be chaired by a prominent, educated public figure of high integrity who does not hold a political position (Adi, 2012; MoH, 2014).

1.1.2 Theoretical Background

The study was guided by stakeholder Theory that was first formally introduced by Edward Freeman (1984). Freeman argued that organizations should consider the interests of all stakeholders, not just shareholders, in decision-making.

Stakeholder Theory assumes that organizations interact with and are accountable to a diverse range of stakeholders, including internal actors such as employees and managers, and external factors such as community members, government agencies, suppliers, and clients. It recognizes that all stakeholders have legitimate interests, rights, or claims in the organization's operations that must be considered. The theory also emphasizes mutual interdependence, highlighting that

the success of an organization relies on satisfying the needs and expectations of its stakeholders. Furthermore, organizational sustainability and effectiveness are achieved through collaboration, by engaging stakeholders, understanding their perspectives, and incorporating their feedback into decision-making processes.

Stakeholder Theory was highly relevant to Health Unit Management Committees (HUMCs) in Health Centre IIIs in Sheema Municipality because it underscores the importance of inclusive decision-making, accountability, and collaboration among multiple stakeholders. HUMCs, composed of community representatives, local leaders, and health workers, reflect this principle by ensuring that diverse voices influence health service delivery. By actively involving patients, local government, and facility staff, HUMCs promote transparency and responsiveness to community needs. The theory also guides committees in balancing competing interests, such as community demands, government policies, and limited resources, fostering collaborative problem-solving. Moreover, stakeholder engagement in planning, monitoring, and evaluation enhances service quality and utilization, supporting broader health goals like Universal Health Coverage (SDG 3, Target 3.8), while continuous participation and support from all stakeholders ensure the sustainability of health services.

1.1.3 Conceptual Background

Health Unit Management Committees (HUMCs) in Uganda are established at the lowest level of public health facilities to empower communities to take responsibility for their health and actively participate in the design, planning, and management of health services (Uganda Health Library, 2020). According to the Ministry of Health (MoH) Uganda, HUMCs promote community participation and ownership of health services, advocate for improved quality of service delivery, and enhance transparency in the management of health facilities (MoH, 2021). Furthermore, studies on HUMCs highlight the importance of comprehensive training and capacity-building programs for committee members to strengthen their effectiveness in monitoring, evaluating, and supporting health unit activities (Minsi, 2023).

Health service delivery refers to the organized provision of health services that enable individuals and communities to access, utilize, and benefit from care. According to the World

Health Organization, it involves the ability to identify, seek, reach, pay for, and engage with health services, with access largely determined by governance decisions regarding service organization and population coverage (NCBI, 2020). It encompasses both personal and non-personal health services, including preventive, promotive, and curative care, organized to ensure continuity of care for individuals (WHO, 2021). Moreover, health service delivery translates health policies, plans, and strategies into concrete interventions that address the health needs of populations, aiming to achieve universal health coverage and improve overall health outcomes (WHO, 2022).

1.1.2 Contextual Background

Uganda's Health Services delivery system is attached to the Country's decentralized system. The public health services are delivered through HCIIIs, IIIs, IVs and in some Districts, District Hospitals at District level, Regional Referral Hospitals (RRHs) and National Referral Hospital (NRHs). They provide Outpatient and Community Outreach Services to clients (MoH, 2019). In addition, they offer complex curative care and depending on their capacity, they act as the first referral, secondly or last referral level curative care facility. They also offer emergency care for the severely injured or the critically ill. They are Centres for transfer of knowledge and skills; they constitute an essential source of information and power; and they generally spend the major part of the National health resources (El-Jardall *et al.*, 2011; MoH, 1999). The Media, CSOs and Community structures such as the VHTs are the other players in service provision and structures (Ibid).

Health Services delivery in Uganda is offered by both Public, Private and Non-Governmental Organizations (NGOs) particularly religious groups with Government being the owner of most facilities under the guidance of Ministry of Health and Ministry of Local Government (MoH, 2010). Ministry of Health plays an oversight role of Health Policy development and provision of health care in all Local Government Hospitals whereas Ministry of Local Government takes charge of health care delivery at the District level and below. Non-Governmental Organizations (NGOs) offers services both in Hospitals and in Small Medical Units (Ibid). The Government services are structured into National, District and Health Sub

District levels (Henrikson *et al.*, 2019). The Health Sub District (HSD) acts as a functional subdivision system, connecting the District Office to the Lower level and improving the planning and management of Sub District Health services. Within the Health Sub district, there are Health Centres (IIs,IIIs and IVs) and Village Health Teams (MoH,1999).

Uganda's Health care system is organized under four levels of care and these include; primary, secondary, tertiary and quaternary. Primary level care comprises of; a network of District and rural Hospitals; tertiary level comprises all General Hospitals at Regional Capital whereas National Hospitals comprise the Quaternary and the highest-level care. With this arrangement, each of the Original 39 District of Uganda has at least a District Hospital and several other small Health Units (HC IVs and IIIs) as it was established that, some 27% of the population were within 5 Kilometers' of the nearest Health Unit whereas the 57% within the 10 kilometers (Uganda Government,1992).

Health Unit Management Committees (HUMCs) in Uganda

Health Unit Management Committees (HUMCs) are key governance structures. They promote participation and ownership of health services by community, advocate for improved quality service delivery, promote transparency in the management of human, material and financial resources. Their establishment is in pursuit of one of the policy objective in the Second National Health Policy which; is to ensure that communities are empowered to play their roles, take responsibility for their own health and ensure that, they actively participate in the design, planning and management of Health services. Their composition and management of Health Unit Management Committees (HUMCs) are laid out in the Ministry of Health Guidelines (MoH, 2019).

Composition of Health Unit Management Committees (HUMCs) for Health Centre IIIs in Uganda.

The Health Unit Management Committees (HUMCs) for Health Centre IIIs are composed of 9 (nine) members whom 3 (three) are women with a minimum academic qualification of ordinary Certificate of Education (UCE) and not holding any political position. The committee consists

of; (i) a public figure of high integrity (chairperson), (ii) staff representative, (iii) Assistant Secretary In-charge of the Sub County, (iv) a Head teacher of a school in the Sub county where the facility is located (member), (v) four community representatives of high integrity including representatives of women, youth and other special interest groups from the parishes with in the Sub County and (vi) Assistant Medical Superintendent (In-Charge) (MoH, 2019).

However, much as the Ministry of Health along with the Government of Uganda created several policies, programmes and departments to empower Local Governments (Districts) to take principal roles in the management of health service delivery and deal with the issue of quality assurance, the performance of the decentralized system has run centrally to the expectations of District Local Governments which has widened regional gaps/inequalities in access to quality health services. There is a dis-connect between policies of the health sector and the operational realities of the situation of health with in communities. The quality of health service has only been a priority with the policy and not implementation. In theory, there are several organizations and review boards in place to ensure that there is not only access to health care but the services being provided are of good quality. Operational realities of quality assurance in relation to health service delivery programmes for effective health care are an undermined examined issue.

Heath service delivery in Uganda and other parts of the Africa has faced the ongoing challenges primarily not limited to insufficient allocation of resources, fragmented and weak health care system and incentive managerial decision making (Lugada *et al.*, 2022). While Health committees cannot directly tackle these issues, they can as well act as vital interface for advocating for necessary changes (Mukiga *et al.*, 2024). This has resulted into situations where the targeted beneficiaries have access to health services and if they do, they are inefficient and of poor quality (Nannyonjo *et al.*, 2013; Onama *et-al.*, 2008).

This trend of poor performance in health service delivery leaves a room for one to question the role of Health Unit Management Committees on Health Service delivery and this calls for a study to examine the roles of Health Unit Management Committees on Health Service delivery in health Centre IIIs by assessing their performance in executing their duties, examining their influence on health service delivery, determining the factors that affects their operations and

suggesting the mechanisms for addressing the factors after their operations in Sheema Municipality, Uganda.

1.2 Statement of the problem

Health service delivery is meant to provide accessible, equitable, efficient, and high-quality health services that meet the needs of individuals and communities. This encompasses universal access to essential preventive, curative, and rehabilitative services without financial hardship, in line with the principles of Universal Health Coverage (UHC) (WHO, 2020). Health service system ensures timely availability of resources, including skilled health workers, essential medicines, and medical equipment, while maintaining transparency and accountability in management (Ministry of Health Uganda, 2020). In a bid to improve health service delivery, Government of Uganda through MOH instituted Health Unit Management Committees (HUMCs) which is pivotal components of the decentralized health system, established at Health Centre IIs, IIIs, and IVs to enhance accountability, efficiency, and community participation. According to the Ministry of Health Uganda (2020), HUMCs are designed to promote community participation and ownership of health services, advocate for improved quality of service delivery, and promote transparency in the management of health services.

However, in Sheema Municipality, the reality paints a different picture whereby health service delivery is 77.2 far below the national level of 99.9% (Ministry of Health, 2023/2024). Despite the presence of Health Unit Management Committees (HUMCs), public health facilities particularly Health Centre IIIs continue to suffer from poor service delivery. There are frequent drug stock-outs, malfunctioning or absent medical equipment, and delayed or poorly managed referrals. Health workers' absenteeism remains high, while cases of misuse or mismanagement of Primary Health Care (PHC) funds are reported (Auditor General, 2024; MoH, 2024; Nanyonga, Kisaakye, & Tumushabe, 2023). These systemic challenges are further exacerbated by the un known challenges for HUMC members, which hinders their ability to effectively monitor health facility performance or enforce accountability among health staff (Hanif & Musvoto, 2022; Atuhaire, Nambatya, & Kaggwa, 2023). The same issues were also raised in the Auditor General's Report FY 2023/2024 for Sheema Municipality and the District Annual

Health Sector Performance Report (AHSPR) FY 2023/2024 which asserts that; staff absenteeism, understaffing especially in specialized critical carders (Laboratory technologist, Clinical Officer and Dispenser), delayed drug deliveries, inadequate basic medical equipment among others over stretches staff beyond he available staff beyond their capacity, creates job related stress and negatively affects health service delivery to the community.

According to related studies such by Tweheyo *et al.*, (2017) and ACODE, 2010, these systemic weaknesses particularly at lower-tier facilities result in poor patient care, limited transparency, and underutilization of public health services. In Sheema Municipality, anecdotal evidence and observations from community members suspected that HUMc do not effectively play their roles in line with planning and budgeting; motivation and incentives; supervision and feedback. If these challenges were not addressed, government health services would collapse, increase the burden of preventable diseases due to poor referrals and delayed care, and ultimately worsen health outcomes. Therefore, this study assessed the role of health unit management committees on health service delivery in health Centre IIIs in Sheema Municipality.

1.3 Objectives of the Study

1.3.1 General Objective

To examine the role of Health Unit Management Committees on Health Service delivery in Sheema Municipality, Uganda.

1.3.2 Specific Objectives

- i. To establish the effect of health unit management committees' planning and budgeting on accessibility of quality health services in Sheema Municipality, Uganda.
- ii. To determine the influence of health unit management committees' motivation and incentives on health service delivery in Sheema Municipality, Uganda.
- iii. To establish the effect of health unit management committees' supervision and feedback on health service delivery in Sheema municipality, Uganda.

1.4 Research Questions

- i. What effects do health unit management committees' planning and budgeting have on accessibility of quality health services in Sheema Municipality, Uganda?
- ii. How has motivation and incentives of health unit management committees' influenced health service delivery in Sheema Municipality, Uganda?
- iii. What effects do health unit management committees' supervision and feedback have on health service delivery in Sheema municipality, Uganda?

1.5 Research Hypothesis

H1: There is a significant positive effect of health unit management committees' planning and budgeting on accessibility of quality health services.

H2: There is a significant positive influence of motivation and incentives on health service delivery.

H3: There is a significant positive effect of health unit management committees' supervision and feedback on health service delivery.

1.6 Scope of the Study

1.6.1 Content Scope

The study sought to examine the role of Health Unit Management Committees (HUMCs) on health service delivery in health Centre IIIs. Specifically, to establish the effect of health unit management committees' planning and budgeting on accessibility of quality health services; to determine the influence of health unit management committees' motivation and incentives on health service delivery and to establish the effect of health unit management committees' supervision and feedback on health service delivery in Sheema municipality, Uganda.

1.6.2 Time Scope

The study covered the Health Unit Management Committees (HUMCs) and health service delivery in health Centre IIIs for the period between 2020 and 2025. That is the period where health delivery in Sheema Municipality was worrying characterized by high mortality rate due to

covid-19; poor health infrastructure, high HIV prevalence and consequently low engagement of HUMc in planning and feedback.

1.6.3 Geographical Scope

The study was conducted in Sheema municipality which is in the heart of Sheema district. The district is bordered by Buhweju District to the north, Mbarara District to the east, Ntungamo District to the south, Mitooma District to the southwest and Bushenyi District to the west. Kibingo, where the district headquarters are located,^[1] lies approximately 33 kilometres (21 mi) west of Mbarara, the largest city in Ankole sub-region.^[2] The coordinates of the district are: 00° 32'S, 30° 24'E. The study covered three (3) HC111s in Sheema municipality such as Kashozi HC111, Kitojo HC111 and Kihunda HC111.

1.7 Justification of the Study

The effective functioning of Health Unit Management Committees (HUMCs) is critical for ensuring quality health service delivery at the community level, particularly in Health Centre IIIs in Uganda. Despite national policies emphasizing community participation and decentralized health management, many health facilities continue to face challenges such as inadequate supervision, poor resource utilization, low staff motivation, and limited community engagement (Ministry of Health, 2022). By focusing on Sheema Municipality, this study sought to generate empirical evidence on how HUMCs influence the planning, coordination, and monitoring of health services, which is currently limited in both local and national contexts. Understanding the role of HUMCs can inform policymakers and health managers on strategies to strengthen governance, enhance accountability, and improve service quality. Furthermore, the findings are expected to guide interventions that empower HUMC members through training, structured incentives, and clearer operational guidelines, ultimately contributing to better health outcomes. This study was timely and relevant because it aligns with Uganda's Health Sector Development Plan (HSDP III) and Sustainable Development Goal 3, which emphasize accessible, equitable, and efficient health services. By highlighting the impact of HUMCs on service delivery, the research provided practical insights for strengthening community-level health governance in Sheema Municipality and similar local government contexts.

1.8 Significance of the Study

The findings of this study provided the Central Government and the Management of Sheema Municipality with valuable evidence on the role and contribution of Health Unit Management Committees (HUMCs) in health service delivery.

Additionally, the study findings helped the Municipality understand effective HUMC practices that should be reinforced or scaled up to enhance public health service delivery. By highlighting successful strategies and identifying gaps, the findings can guide interventions aimed at improving the responsiveness of health services to community needs, ultimately contributing to the achievement of Uganda's National Development Goals, including Universal Health Coverage and improved population health outcomes.

The study findings also contributed to the improvement of national health policy frameworks. Insights generated can inform the Ministry of Health on evidence-based approaches to strengthen health service delivery at the local level. While the focus is on HUMCs, the findings may also suggest broader policy improvements that enhance service delivery without necessarily relying exclusively on HUMCs, ensuring a more comprehensive and sustainable approach to health system strengthening.

Furthermore, the study provided background information on the current state of health service delivery in relation to HUMCs. This baseline data will help stakeholders, including local government officials, health facility managers, and community members, understand how HUMCs operate, their challenges, and their contributions to health outcomes. Such information is critical for planning, monitoring, and evaluating future interventions in the health sector.

The research findings also served as a reference point for scholars and future researchers interested in studying health governance, community participation, and the role of HUMCs in health service delivery. By documenting methodologies, findings, and lessons learned, the study contributed to the academic literature and provides a foundation for further investigations in this area.

Finally, the successful completion of this study enabled the researcher to be awarded a Master of Arts in Public Administration and Management from Bishop Stuart University, marking the culmination of rigorous academic training and contributing to the researcher's professional and scholarly development in the field of public health management.

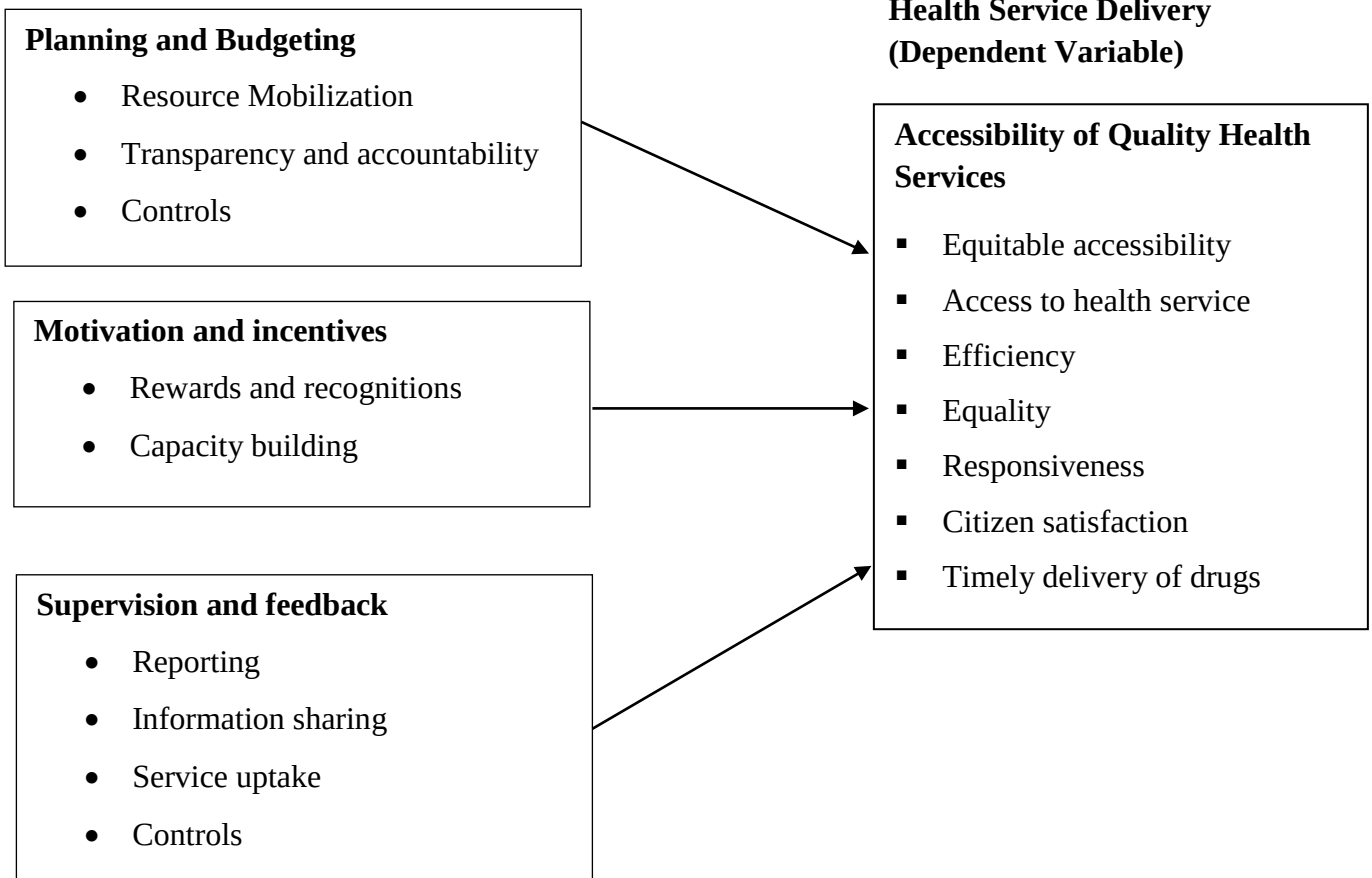
1.8 Conceptual Framework

This conceptual frame work provides the link between the independent and dependent variables of the study. It is intended to assess the extent to which the dependent variable depends on the independent variable. The conceptual frame work show how the research is guided, endorsed, and validated by the structure of concepts, expectations and beliefs and is a key part of the research design. In this case, Health Unit Management Committees were conceived as independent variable (IV) while Health Service delivery were the dependent variable (DV). The conceptual frame work describes the relationship between variables as shown below in Figure 1;

Figure 1: Conceptual Framework for Health Unit Management Committees and Health Service Delivery

Independent Variable

Health Unit Management Committees



Source: Adapted from Freeman (1984) and modified by the researcher (2025)

The conceptual framework for this study illustrates the relationship between Health Unit Management Committees (HUMCs) as the independent variable and Health Service Delivery as the dependent variable in health Centre IIIs in Sheema Municipality. HUMCs play a crucial oversight and governance role through activities such as planning and budgeting, motivation and incentives, and supervision and feedback. Under planning and budgeting, HUMCs contribute to

resource mobilization, promote transparency and accountability, and establish internal controls that ensure proper use of health resources. In terms of motivation and incentives, HUMCs can enhance health worker performance through rewards, recognitions, and advocating for capacity building initiatives. Through supervision and feedback, they support regular reporting, encourage information sharing, enhance service uptake, and enforce operational controls. These roles collectively impact the delivery of health services in various ways. Effective planning and oversight by HUMCs leads to improved accessibility of quality health services, proper accountability for resources, and enhanced health worker performance. Furthermore, strengthened HUMC functionality reduces unnecessary referrals, ensures availability of medical equipment, improves citizen satisfaction, enables timely delivery of essential drugs, and promotes equitable access to healthcare services. Therefore, the effectiveness of HUMCs in executing their responsibilities directly influences the quality and efficiency of health service delivery in Health Centre IIIs within Sheema Municipality.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This Chapter of the study focused on the review of relevant literature to the study. The review was conducted under the themes which were formulated in line with the objectives of the study in an effort to seek affirmation that were raised under the study. The review based on definition of key terms, Global, Regional, National and local perspectives and interventions on health service delivery and the Synthesis of the literature review and the knowledge gap. This review is very key as it relates to other studies conducted in different parts of the World.

2.1 Theoretical review

This study was guided by the stakeholder Theory that was first propounded by Edward Freeman (1984). Stakeholder is any group or individual who can affect or is affected by the achievement of the organization's objectives and suggests that shareholders are merely one of many stakeholders in a company (Freeman, 2010).

The approach to stakeholder theory is suggested as an alternative to that of shareholder theory (Goyal, 2022). The theory argues that a firm should create value for all stakeholders, not just shareholders. Stakeholder theory is a view of capitalism that stresses the interconnected relationships between a business and its customers, suppliers, employees, investors, communities and others who have a stake in the organization (Minoja, 2012).

Stakeholder theory is based on the assumption 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 (Freeman, 1984). This means that profit alone cannot be considered the only measure of business success. It also assumes that it's not just shareholders who contribute to a company's success and that stakeholders have a direct impact on a company's operations. The stakeholder theory makes it clear that directors have a responsibility to shareholders and stakeholders alike (Tse, 2011). Stakeholder theory assumes that organizations have an ethical duty to make decisions that consider the well-being of all stakeholders rather than making

decisions solely based on economic profit or shareholder returns. Lastly, stakeholder theory assumes that decision-making in organizations should involve or at least consider the interests of all relevant stakeholders through formal mechanisms like boards and committees or informal feedback channels.

Several recent studies have successfully applied Stakeholder Theory to explore complex relationships in health service delivery and organizational management. For instance, Freeman et al. (2018) examined stakeholder engagement in public health policy development, emphasizing inclusive participation for better outcomes. Greenwood and Freeman (2019) applied the theory to healthcare organizations, highlighting the balancing of diverse stakeholder interests to improve service quality. Nash et al. (2020) used Stakeholder Theory to analyze multi-stakeholder collaboration during health emergencies, demonstrating its role in effective coordination and resource allocation. More recently, Ochieng and Dodd (2022) investigated stakeholder dynamics in community health program implementation in East Africa, showing how stakeholder power and legitimacy influence success. These studies illustrate the theory's relevance and practical application, providing a strong foundation for understanding how community participation and diverse stakeholder involvement shape health service delivery in the context of UCREPP.

However, Stakeholder theory is criticized because it appears to have shortcomings regarding aspects of concerning normative, descriptive, and instrumental approaches as well as the submission of theory to organizational certainties and the development of the theoretical body of work (Gerard, 2022). For instance, Freeman's (2010) attentiveness towards stakeholder theory is more technical instead theoretical, which lacks the theoretical platform in effectively explaining either the behavior of the organization or that of individuals or group entities, whether internal or external. Furthermore, Bag et al. (2024) argues that stakeholder theory does not sufficiently clarify operational processes within organizations by interlinking internal and external variants, or incongruously evaluating the environment. Nevertheless, Lalu (2024) denote that despite inadequately identifying internal and external interest groups in stakeholder theory, entities may be associated as an employee related to internal interest groups, shareholders and employees,

external stakeholder groups, professional and consumer organisations, environmental activists, and community action entities.

Dmytriyeu and Freeman (2023) notes that stakeholder theory inaccurately considers the environment as static, fixated against the organization and intended only for stakeholder groups. Moreover, Freeman (2010) claims that an organization's social concerns and responsibilities should not be separated from its core organizational strategies and policies and that the effect of social and economic concerns cannot be separated (Dmytriyeu & Freeman, 2023). Though, Freeman's model does not stipulate an understanding of the process concerning the overall system containing the organization's environment (Dmytriyeu & Freeman, 2023).

2.2 Empirical Review

2.2.1 Health unit management committees' planning and budgeting on accessibility of quality health services.

Alderwick et al. (2024) conducted a qualitative study in England exploring how health and social care organisations within the NHS Integrated Care Systems (ICSs) collaborated with community partners to address health inequalities. The study revealed that integrated planning structures which incorporate community representation and enable pooled or flexible funding create important opportunities to tailor services to local needs and overcome access barriers. Community involvement helped identify social determinants of health and contextual barriers to quality care, thereby enhancing the responsiveness of services. However, the authors emphasised that meaningful impact on accessibility and quality requires community representatives to hold formal decision-making authority and clear influence over budgetary allocations.

Chudyk et al. (2024) highlight the importance of patient, family, and community engagement in health planning through structures such as Patient and Family Advisory Councils (PFACs) and community advisory bodies in the Canadian context. Their participatory study shows that these committees can strengthen the alignment of health services with community needs by identifying gaps in access and quality, while also improving trust and accountability between providers and service users. However, the authors stress that for such committees to move beyond symbolic

consultation and achieve tangible outcomes, they must be adequately resourced through discretionary budgets or formal influence over planning cycles granted access to relevant data, and supported with budget literacy training.

Dutta (2025) explored the implementation of agile planning frameworks within Ghana's primary healthcare system and their impact on stakeholder responsiveness and resource allocation. The study revealed that health facilities and local management committees, including HUMC equivalents, that adopted agile planning methods characterized by iterative planning cycles, real-time data use, and adaptive budgeting experienced significant improvements in aligning resources with emerging community health needs. Stakeholders, including district health teams and community representatives, reported enhanced participation and faster decision-making, which led to improved service coverage and reduced delays in drug procurement and staff deployment. Dutta highlighted that agile approaches enabled HUMCs to anticipate challenges, make timely adjustments, and foster accountability through more frequent reviews and feedback loops. The study concluded that integrating agile planning into local health governance structures strengthens the capacity of committees like HUMCs to deliver responsive, efficient, and people-centered health services.

Piatti Fünfkirchen et al. (2020) investigated the impact of local budgetary control on health service planning effectiveness in Malawi. Their study found that limited financial autonomy at the local health facility level significantly constrained the ability of Health Unit Management Committees (HUMCs) to plan and respond to community health needs effectively. Despite the existence of budgeting frameworks, strict central control over funds meant that HUMCs had little discretion in reallocating resources or adjusting plans in response to emerging challenges. This lack of control led to rigid, often unrealistic plans that did not align well with on-the-ground realities, resulting in inefficiencies and reduced service quality. The authors highlighted that empowering local committees with greater budgetary authority, combined with capacity-building efforts, is crucial to enhancing the responsiveness and effectiveness of health planning at the community level.

Hanif and Musvoto (2022) conducted a study in Malawi that highlighted the critical role of effective budgeting practices in determining the quality of health service delivery at district-level hospitals. The researchers found that budgeting processes in many health facilities were characterized by rigidity, delayed fund disbursement, and limited autonomy at the local level. These challenges undermined timely procurement of essential supplies, hindered service planning, and restricted the flexibility needed to respond to emerging health priorities. As a result, service delivery suffered, particularly in areas like maternal and child health, where delayed interventions could have life-threatening consequences. The study concluded that strengthening budget flexibility, timely funding, and capacity for local financial decision-making are essential for improving accessibility and quality of health services in resource-limited settings.

Kabongo and Mbonigaba (2024) conducted a regional study across Sub-Saharan Africa to examine how governance practices in budgeting affect health outcomes, particularly for children. Their findings revealed that health systems characterized by good governance—marked by transparency, stakeholder participation, financial accountability, and strategic oversight—were more likely to allocate budgets effectively and respond to priority health needs. In contexts where Health Unit Management Committees (HUMCs) or similar local governance structures were actively involved in budgeting processes, there were measurable improvements in child health indicators such as immunization coverage, reduction in malnutrition rates, and increased access to essential pediatric care. The study emphasized that beyond the availability of funds, the way resources are planned, allocated, and monitored determines their impact. Kabongo and Mbonigaba concluded that strengthening governance frameworks at both central and local levels, including empowering HUMCs, is vital for translating health budgets into tangible service delivery gains especially for vulnerable populations like children.

O'Meara et al. (2020) examined the effectiveness of Health Unit Management Committees (HUMCs) in district-level planning within Kenya's devolved health system. The study found that while HUMCs were formally included in the planning and budgeting structures, their actual influence was limited due to procedural demotivation. This demotivation stemmed from factors

such as top-down planning directives, lack of access to relevant data, and inadequate training on budgeting frameworks. As a result, many HUMC members felt sidelined and disengaged, which weakened their contribution to health service planning. The study further noted that delayed feedback from higher authorities and limited transparency in fund allocation discouraged committee members from participating actively. O'Meara et al. concluded that without meaningful empowerment through capacity building, access to information, and structured feedback mechanisms HUMCs risk becoming symbolic rather than functional entities in health governance, thus undermining efforts to improve local health service delivery.

Arie et al. (2022) explored the implementation of program-based budgeting (PBB) within Kenya's county health systems and its effects on aligning resources with community health priorities. The study found that adopting PBB frameworks enabled Health Unit Management Committees (HUMCs) and county health managers to shift from traditional input-focused budgeting to a more outcome-oriented approach. This shift facilitated the allocation of funds directly to priority health programs identified through community engagement, such as maternal health, immunization, and infectious disease control. The researchers observed that PBB improved transparency and accountability by linking budget expenditures to measurable health outcomes, thus enhancing stakeholder trust. Moreover, the participatory nature of PBB empowered HUMCs to advocate for resources that better reflected local needs, resulting in more relevant and effective service delivery. Arie et al. (2022) concluded that institutionalizing program-based budgeting strengthens the responsiveness of health systems to community health demands.

Muwanguzi et al. (2020) carried out a study in the Busoga sub-region of Uganda, focusing on the relationship between Health Unit Management Committees (HUMCs) and health facility performance. The findings revealed that when HUMCs were actively engaged in planning processes such as contributing to the development of annual work plans, setting priorities, and participating in resource allocation health facilities demonstrated improved service delivery outcomes. These included better staff coordination, more efficient drug procurement, and enhanced responsiveness to community health needs. The study emphasized that meaningful

HUMC participation fostered a sense of ownership and accountability, which translated into more effective management of health services. The authors recommended strengthening HUMC capacity and embedding participatory planning as a strategy for improving accessibility and quality in primary healthcare delivery.

MedRxiv Busoga Study (2024) examined the effect of Health Unit Management Committees' (HUMCs) planning competencies on health facility performance in the Busoga sub-region of Uganda. The study found a strong positive correlation between the competence of HUMCs in developing and implementing annual work plans and the overall improvement in facility-level health outcomes. Facilities with well-trained and actively engaged HUMCs reported more efficient use of resources, timely delivery of essential services, and increased community satisfaction. The study highlighted key aspects of effective planning, including realistic budgeting, alignment with local health priorities, and regular review of targets. It concluded that empowering HUMCs through planning tools, mentorship, and technical support significantly contributes to enhanced accessibility and quality of health services.

Tsofa et al. (2021) investigated the role of budgeting practices specifically forecasting and periodic reviews in improving health service delivery within Uganda's decentralized health system. The study revealed that health facilities where HUMCs were involved in regular budget forecasting, monitoring, and mid-year adjustments experienced notable improvements in service delivery outcomes. These improvements included better availability of essential medicines, reduced stock-outs, and more efficient deployment of health workers. The researchers emphasized that periodic budgeting allowed HUMCs and facility managers to remain responsive to shifting needs and to reallocate resources based on performance gaps. Furthermore, the study found that such budgeting practices enhanced transparency and accountability, particularly when financial updates were routinely shared with community stakeholders. Tsofa et al. concluded that institutionalizing participatory and iterative budgeting processes can significantly strengthen primary healthcare delivery and community trust in the health system.

Ntitandekura et al. (2022) conducted a study in Uganda focusing on the relationship between budget adherence and the successful implementation of health facility plans. The research revealed that strict adherence to approved budgets by Health Unit Management Committees (HUMCs) significantly enhanced the execution of planned activities, particularly in drug procurement, facility maintenance, and community outreach programs. Facilities where budgets were consistently followed reported fewer interruptions in service delivery and better alignment between allocated funds and community health priorities. Conversely, deviations from the budget often due to late disbursements or reallocation of funds without stakeholder involvement led to delays and inefficiencies. The study emphasized the importance of financial discipline and regular budget tracking as critical components for effective planning. Ntitandekura et al. (2022) concluded that strengthening financial oversight and ensuring budget discipline among HUMCs are key to achieving consistent improvements in the accessibility and quality of health services.

Gambo et al. (2021) conducted a comprehensive literature review examining the multifaceted role of budgeting within health organizations, emphasizing its functions as a critical tool for planning, control, and enhancing organizational performance. Their analysis revealed that effective budgeting facilitates strategic allocation of resources, enabling health management committees including Health Unit Management Committees (HUMCs) to align financial inputs with service delivery goals. Furthermore, budgeting serves as a control mechanism by providing benchmarks for monitoring expenditures and ensuring accountability. The review highlighted that organizations with well-structured budgeting processes experience improved operational efficiency, transparency, and service quality. Gambo et al. (2021) concluded that integrating participatory budgeting with robust monitoring systems is essential for health committees to optimize performance and sustainably improve healthcare accessibility and quality.

Er Rays and M'dioud (2024) examined the relationship between financial efficiency and the quality of maternal and child health services, emphasizing the pivotal role of effective planning in achieving care improvements. Their study demonstrated that health facilities with well-structured financial planning characterized by accurate budgeting, timely allocation, and judicious use of funds were better positioned to deliver high-quality maternal and child

healthcare. Efficient financial management enabled consistent availability of essential supplies, staffing, and timely interventions, which directly contributed to improved health outcomes such as reduced maternal mortality and better child immunization coverage. The authors argued that meticulous planning processes within Health Unit Management Committees (HUMCs) are vital for maximizing the impact of limited resources and enhancing overall service quality. This study reinforces the critical link between sound financial planning and the accessibility and effectiveness of essential health services.

2.2.2 Health unit management committees' motivation and incentives on health service delivery.

Alderwick, Hutchings and Mays (2024) studied a qualitative study of England's Integrated Care Systems (ICSs), leaders reported that community representatives and local governance bodies are most effective when their participation is supported by clear decision-making authority, access to pooled or flexible funds, and formal mechanisms that tie community priorities to budgetary processes. Motivation for community partners was strongest when they could see how their input changed commissioning or service delivery; conversely, engagement proved demotivating where participation was consultative without budgetary influence. The study therefore emphasises that incentives which convert advisory input into funded action (formal roles, delegated funds, and feedback on impact) are critical to translate motivation into improved access and quality.

Dutta (2025) explored the implementation of agile healthcare frameworks in low-income countries, focusing on Ghana. The study highlighted that adopting agile methodologies—characterized by iterative planning, real-time data utilization, and stakeholder collaboration—significantly enhanced project ownership and motivation among health managers. By fostering a culture of adaptability and continuous feedback, these frameworks empowered local health teams to take greater responsibility for project outcomes, leading to improved service delivery and resource allocation. The study concluded that integrating agile practices into health management systems can drive more responsive and effective healthcare interventions in resource-constrained settings.

Msendma et al. (2021) conducted a qualitative case study in Malawi to explore how data quality management practices within Health Management Information Systems (HMIS), specifically using the DHIS2 platform, gain legitimacy among medical practitioners. The study found that recognition of these practices through isomorphic processes such as mimetic, coercive, and normative influences was crucial for their acceptance and effective implementation. Mimetic isomorphism led to moral and pragmatic legitimacy, while normative isomorphism contributed to cognitive legitimacy, thereby enhancing the correctness and timeliness of health data and reports. The authors argue that leveraging these isomorphic forces can motivate health service managers to legitimize data quality management practices among health practitioners, ultimately improving data quality in HMIS.

Er-Rays and M'dioud (2024) conducted a study assessing the technical efficiency of Morocco's public hospital network using Data Envelopment Analysis (DEA). Their findings revealed that the average technical efficiency score of these hospitals was 0.697, indicating that the facilities were operating at approximately 70% of their potential efficiency. This suggests that improvements in resource utilization could enhance service delivery without additional investments. The study also highlighted that factors such as the number of hospitals, physicians, and paramedical staff, as well as the functional capacity, hospitalization days, and admissions, played significant roles in determining efficiency levels. These insights underscore the importance of strategic planning and resource management in improving healthcare efficiency.

Kabongo and Mbonigaba (2024) investigated the moderating role of governance in the relationship between public health spending and population health outcomes in Sub-Saharan Africa. Their study, published in *Health Research Policy and Systems*, utilized partial least squares structural equation modeling (PLS-SEM) to analyze panel data from 43 countries over the period 2013–2019. The findings revealed that domestic general government health expenditure (DGGHE) negatively affected disability-adjusted life years (DALY), indicating improved health outcomes. Furthermore, the study found that the quality of governance specifically, dimensions such as corruption control, government effectiveness, and voice accountability significantly enhanced the impact of DGGHE on DALY. Notably, countries with

poorer governance experienced more substantial improvements in health outcomes, suggesting that strengthening governance structures can amplify the effectiveness of health spending.

Lutwama et al. (2022) conducted a qualitative study in South Sudan to explore supportive supervision practices in health services during a protracted crisis. The study found that many health supervisors lacked formal training in supportive supervision, which led to challenges in effectively guiding and motivating health workers. This lack of training resulted in supervisors relying on informal, on-the-job learning, which often lacked consistency and structure. Consequently, the quality of supervision was compromised, affecting the morale and performance of health workers. The study emphasized the need for structured training programs to enhance supervisors' competencies, thereby improving the quality of supervision and overall health service delivery in crisis settings.

Gangu (2021) investigated the impact of targeted training programs on the performance of Health Unit Management Committees (HUMCs) and their working relationships with health facility staff in Uganda. The study found that providing HUMC members with capacity-building workshops significantly improved their understanding of governance roles, financial management, and planning processes. This enhanced competence not only increased their confidence in overseeing health service delivery but also fostered stronger trust and collaboration with health workers. Facilities where trained HUMCs were active reported improved coordination, more transparent decision-making, and better responsiveness to community health needs. Additionally, the study highlighted that ongoing mentorship and refresher trainings helped sustain these positive outcomes. Gangu concluded that investing in regular and context-specific training for HUMCs is essential to empower committees, strengthen health governance, and ultimately improve service quality and accountability.

Uganda CHW Study (2023) examined how a combination of financial and non-financial incentives influenced the performance of community health workers (CHWs) in Uganda. The study found that providing CHWs with financial rewards such as stipends and transportation reimbursements, alongside non-financial incentives like public recognition, training opportunities, and provision of uniforms, significantly increased their motivation and

commitment. This integrated incentive approach led to improved service delivery outcomes, including more frequent household visits, enhanced health education, and timely provision of community health services. Moreover, the combined incentives contributed to higher retention rates among CHWs, ensuring continuity of care in underserved areas. The study highlights that holistic incentive packages are essential for sustaining CHW engagement and optimizing the delivery of vital community health services.

The ICWEA–Global Fund Initiative (2022) utilized the Community Score Card (CSC) as a participatory tool to enhance the engagement of Health Unit Management Committees (HUMCs) in Uganda. By orienting HUMCs in districts such as Nakasongola and Gulu on the CSC and their broader roles, the initiative aimed to bridge information gaps and strengthen community involvement in healthcare oversight. This orientation empowered HUMCs to actively monitor and supervise health facilities, ensuring quality care and adherence to commitments made during the dissemination of the CSC. Notably, many HUMC members were previously unaware of their responsibilities in planning and budgeting processes. With newfound knowledge, they committed to advocating for resource allocation that prioritizes community awareness creation, thereby enhancing healthcare delivery in their respective districts.

2.2.3 Management committees’ supervision and feedback on health service delivery

American Hospital Association (2022) highlighted the centrality of hospital boards in supervising quality and acting on feedback loops from frontline services. The AHA’s National Health Care Governance Survey (2022) and Joint Commission commentary (2023) report that boards that regularly review quality dashboards, require follow-up on adverse events, and set explicit expectations for management feedback are more likely to hold executives accountable for safety and performance. In practice, boards create supervision/feedback influence by (a) mandating routine presentation of process and outcome metrics, (b) establishing quality committees that drill into root causes, and (c) insisting on management action plans with tracked follow-up which together strengthen organisational learning and improve measurable care processes.

PMC Supervision (2021) examined the impact of structured group supervision on team learning among allied health professionals in a regional health service in Victoria, Australia. Using a critical reflection model, the program engaged professionals and managers in group sessions focused on activities like data collection, problem-solving, and ongoing education. Participants valued the diverse perspectives, opportunities for reflection, peer support, and the organized group processes, which together enhanced learning and collaboration. The study highlighted that successful group supervision relies on organizational backing, skilled facilitators, and careful planning. Similarly, a mixed-methods study across Ethiopia, Kenya, Malawi, and Mozambique showed that group supervision interventions including training and mentorship for supervisors—boosted community health workers’ motivation and performance by fostering recognition, support, and teamwork. Together, these findings emphasize that group supervision frameworks are powerful tools for promoting collective learning and improving health workforce effectiveness.

BMC Tanzania e-TIQH (2024) evaluated the impact of digital supervision tools combined with real-time feedback on healthcare quality in Tanzanian primary health facilities. The initiative utilized mobile technology to conduct on-site assessments across multiple quality domains, including clinical practices and staff performance. Immediate feedback provided to healthcare workers enabled rapid identification and correction of service gaps, fostering a continuous improvement culture. The study found that facilities using e-TIQH demonstrated significant improvements in adherence to clinical guidelines, staff motivation, and patient satisfaction. By streamlining data collection and promoting accountability through timely feedback, the digital supervision approach empowered health workers to take active ownership of quality enhancement efforts, ultimately leading to better health outcomes for the communities served.

Supportive Supervision Tanzania (2019) implemented a strengthened supportive supervision approach led by Council Health Management Teams (CHMTs) to enhance the quality of primary healthcare services. This initiative integrated routine assessments using the electronic Tool to Improve Quality of Healthcare (e-TIQH), enabling CHMTs to conduct systematic quality evaluations across health facilities. The process involved direct observations, interviews with

healthcare providers, and real-time data collection, followed by immediate feedback sessions. This approach not only identified areas for improvement but also fostered a collaborative environment where healthcare providers actively engaged in addressing quality gaps. As a result, there were notable improvements in various quality dimensions, including infection prevention and control practices, availability of clinical guidelines, and staff motivation. The integration of structured feedback into routine supervision proved to be a pivotal factor in driving sustainable quality enhancements in Tanzania's primary healthcare system.

Msendma et al. (2021) studied how supervision focused on data quality within Malawi's Health Management Information System (HMIS) using the DHIS2 platform helped legitimize accurate and timely reporting behaviors among health workers. Their research showed that through mechanisms like mimicking best practices, normative professional standards, and coercive accountability measures, health workers came to view high-quality data management as both a moral and practical responsibility. This legitimization encouraged more consistent adherence to data protocols and improved the reliability of health information reporting. The study highlights the importance of supportive supervision and institutional norms in fostering a culture of data quality, which is crucial for evidence-based decision-making in health service delivery.

Kabongo and Mbonigaba (2024) investigated how governance influences the effectiveness of public health spending in Sub-Saharan Africa using data from 43 countries between 2013 and 2019. Their study showed that increased government health expenditure was associated with better health outcomes, measured by reductions in disability-adjusted life years (DALYs). Importantly, governance factors such as corruption control, government effectiveness, and voice accountability significantly amplified the positive impact of health spending. Interestingly, countries with weaker governance saw even greater improvements when governance mechanisms were strengthened, highlighting that good governance and oversight play a critical role in ensuring that health budgets translate into tangible health benefits. This study emphasizes the need for governance-based supervision to maximize the efficiency and impact of health expenditure in the region.

The PMC Supervision Advances (2021) study underscores the critical role of dedicated supervisors in enhancing Community Health Worker (CHW) performance. Findings indicate that consistent and supportive supervision, characterized by regular visits and constructive feedback, significantly boosts CHW motivation and service delivery quality. This approach fosters a collaborative environment, enabling CHWs to address challenges effectively and improve health outcomes. The study emphasizes that investing in dedicated supervisory roles is essential for optimizing CHW effectiveness and sustaining quality healthcare services.

The Uganda Accountability Meetings (2024) initiative demonstrated that structured community feedback sessions involving local politicians significantly influenced healthcare provider behavior. Held quarterly in Western Uganda, these meetings brought together community members and local council leaders to discuss healthcare service quality and address concerns. Participants reported increased awareness of patient rights and a sense of collective empowerment, leading to improved provider conduct and reduced absenteeism. The initiative fostered bidirectional communication, enhancing relationships among community members, healthcare providers, and politicians, thereby promoting accountability and responsiveness in health service delivery.

Dutta (2025) examined how applying agile, iterative feedback mechanisms in healthcare planning improved resource allocation in Ghana's health system. The study found that by using regular, real-time feedback loops involving stakeholders at various levels, health managers were able to make timely adjustments to budgets and service delivery plans. This flexibility allowed resources to be redirected quickly to address emerging health priorities and inefficiencies, resulting in better alignment between community needs and available services. Dutta highlighted that the agile approach fostered greater collaboration, transparency, and responsiveness, ultimately enhancing the efficiency and effectiveness of healthcare interventions in resource-limited settings.

2.3 Summary of the literature review

The literature consistently highlights that Health Unit Management Committees (HUMCs) play a pivotal role in enhancing the accessibility and quality of health services through effective planning, budgeting, motivation, and supervision. Studies such as those by Muwanguzi et al. (2020) and Kabongo & Mbonigaba (2024) demonstrate that strong HUMC involvement in participatory planning and transparent budgeting processes directly improves resource allocation, leading to better service availability and reduced referrals. Motivation and incentives, both financial and non-financial, have been shown by Uganda CHW Study (2023) and Gangu (2021) to increase HUMC members' commitment and performance, fostering active engagement and trust with health workers, which translates into improved service delivery. Furthermore, supervision and feedback mechanisms, as evidenced by PMC Supervision (2021) and Lutwama et al. (2022), strengthen accountability and continuous quality improvement by providing timely guidance and encouraging data-driven decision-making. Digital tools and community feedback loops, highlighted in studies from Tanzania and Uganda, further enhance supervision effectiveness by promoting transparency and responsiveness. Collectively, this body of research underscores that the synergistic effect of robust planning, motivated committees, and structured supervision substantially improves health service delivery outcomes, accessibility, and community satisfaction in resource-limited settings.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the research methods and procedures that were used to conduct the study right away from the design, data collection to the analysis of the data.

3.1 Research Design

This study employed a case study research design, utilizing both qualitative and quantitative approaches. A case study design was chosen because it allows the researcher to study the subject in detail and comprehensively (Yin, 2009). According to Amin (2005), this research design provides an in-depth examination of a problem within a limited period of time. The quantitative approach involved the use of questionnaires to collect data, enabling the researcher to describe the current situation and examine the relationship between Health Unit Management Committees (HUMCs) and health service delivery in Sheema Municipality, Uganda. This approach was chosen because it is flexible and uses multiple scales with indices focusing on the same construct, allowing for different responses based on respondents' knowledge, attitudes, and experiences (Nunnally, 1978). The qualitative approach included the use of interview guides and observation checklists to gather data aimed at providing narrative and interpretive insights, complementing the quantitative findings. The combination of both approaches enabled the researcher to minimize the bias associated with using a single research approach (Mugenda & Mugenda, 2003).

3.2 Area of Study

The study was conducted in Sheema Municipality in the South Western Uganda. It is bordered by Bushenyi in the West, Ntungamo in the south and Mbarara District in the East. It lies between 00 25'0'' South and 00 45'0'' South and longitudes 30 30'0'' East and East with an average altitude of 1,500 metres above sea level. The Municipality has a land area of 243.4 square kilometers and a population of 81,564 as of 2014 National population and housing census (SMC, 2020). The study covered the health Centre IIIs with in the three Divisions of Sheema

Municipality namely, Kagango, Kashozi and Sheema Central Division. The selection of HC IIIs serve as the first referral points and are responsible for providing comprehensive basic health services, including outpatient care, maternal and child health, and disease prevention, making them critical in the local health system. Focusing solely on HC IIIs allows for an in-depth assessment of governance, service delivery challenges, and the effectiveness of the Health Unit Management Committees (HUMCs) in managing these facilities.

3.3 Study population

The study targeted 129 respondents that were categorized as: community members, municipal health officers, health in-charges, district health officers, district biostatisticians, town clerks, secretaries for health and social services, and Chairpersons of Health Unit Management Committees (HUMCs). These respondents were purposively selected because they play direct and critical roles in health service delivery and governance. Care takers provide firsthand insights into the accessibility, quality, and responsiveness of health services, reflecting the community's perspective. Municipal health officers, health in-charges, and district health officers are responsible for planning, supervision, and management of health facilities, making them key informants on operational processes and resource utilization. Biostatisticians contribute expert knowledge on health data management and service monitoring, which is essential for understanding trends and outcomes. Town clerks, secretaries for health and social services, and HUMC Chairpersons provide governance and policy perspectives, particularly regarding oversight, accountability, and community participation. Including these diverse categories ensures a holistic understanding of the relationship between HUMCs and health service delivery, triangulating information across multiple levels of the health system to enhance validity and reliability of the study findings.

3.4 Sampling techniques and procedure

A sample of 111 respondents were selected for the study from the three categories of; Community members, Community Members/Clients and Key informants/Politicians. The researcher employed the estimation method of sample determination to get a representative sample. This was assisted by purposive and simple random sampling techniques. Bartlett *et al.*,

2001, argues that, the researcher should use 50% of an estimate of percentage of sample with the same characteristics (P) as this result in the maximum variance and produce a minimum sample.

The Three (3) Health Centre IIIs were considered from the divisions of the Municipality and a total of 80 case takers/ community members was randomly selected. Simple random sampling is where every case of the population has an equal chance of being selected or probability of inclusion in the sample (Ghauri et al., 2005). Purposive sampling was employed to select 3 Health Centre IIIs from the three Divisions, 08 Politicians (from Executive Committee Members of the Divisions) were selected. This helped to get some particular key information from respondents.

3.4.1 Distribution of Respondents

A total of 111 respondents were selected from the three categories of respondents. In this respect, 80 Community members/patients were randomly selected while 1 Municipal health officer, 3 Health in-charges, 18 End users/ patients, 1 Biostatistician, 1 Town clerk, 1 Secretary for social services, 1 Chairperson HUM and 3 Chairperson LC III as shown in the Table 3.1.

Table 3. 1 Showing the Distribution of Respondents

SN	Category	Target population	Sample size	Sampling technique
1	Care takers	100	80	Simple random
2	End users/ patients	18	18	Purposive sampling
3	Municipal health officer	1	1	Purposive sampling
4	Health in-charges.	3	3	Purposive sampling
5	Biostatistician	1	1	Purposive sampling
6	Town clerk	1	1	Purposive sampling
7	Secretary for social services	1	1	Purposive sampling
8	Chairperson HUM	3	3	Purposive sampling
9	Chairperson LC III	3	3	Purposive sampling
	Total	131	111	

Source: Human Resource Manual (2024); Health in-charge Report (2024); DHO report (2023) and modified by researcher (2025)

3.5 Data Collection Methods

This study employed both qualitative and quantitative research approaches to collect data from both primary and secondary sources. Primary data were got from the field. It was used because it is reliable and dependable with accurate information without bias (Mugenda & Mugenda, 2003). Data from community members were collected using open and close ended Questionnaires while the Interviews were used to collect data from the community members and the Politicians. Observation method were used to study the general health service delivery at the Health Centre. This helped to create meaning out of the relevant observed aspects.

3.5.1 Questionnaire Survey Method

The researcher employed a close-ended questionnaire survey that was administered to community members. The questionnaire contained pre-formulated response options to ensure consistency and ease of analysis. Respondents were first introduced to the purpose of the research through an introductory letter and verbal explanations, which enhanced transparency and encouraged cooperation. This procedure helped to improve the credibility of responses by ensuring that participants were well-informed about the study's aims. Close-ended questions also reduced ambiguity, minimized interviewer bias, and facilitated the collection of comparable, standardized data across a relatively large sample, which is critical in ensuring the reliability and validity of quantitative studies (Taherdoost, 2022). The questionnaire was used to capture primary data directly from community members, focusing on their perceptions and experiences relevant to the research objectives. The researcher ensured that all participants responded to the same set of questions in the same format, allowing for statistical analysis and the identification of trends and associations. This systematic approach to data collection also made it possible to maintain objectivity and to compare results across demographic groups (Fetters, 2023).

3.5.2 Interview method

Interview is a data collection method which basically involves the researcher and the respondent. During the process, a researcher follows the designed interview guide to help him/her proceed with his /her research (Muganda & Mugenda, 1999). In this study, face to face interviews were carried out personally with 18 end-users/patients, 1 Municipal health officer, 3 Health in-

charges, 1 Biostatistician, 1 Town clerk, 18 end user/patients 1 Secretary for social services, 1 Chairperson HUM and 3 Chairperson LC III with the aim of getting information from them and the responses were written down/recorded for analysis. The interviews were conducted personally, following the pre-drafted interview guide designed to cover key topics related to health service delivery, accessibility, and committee functionality. Responses were recorded and written down for systematic analysis, enabling the researcher to capture verbatim accounts, identify patterns, and cross-check information across different respondents. This approach allowed the researcher to gather rich, detailed, and context-specific data directly from stakeholders involved in health service planning and delivery. Face-to-face interviews facilitated clarification and probing, allowing respondents to explain complex or sensitive issues in their own words, which improved the depth and reliability of data (Creswell & Creswell, 2024).

3.5.3 Observation Method

This is where the researcher uses all senses to gather information about the phenomena under the study (Sekaran, 2024). With this method, the researcher passively collected data concerning the infrastructure, equipment at the Health Centre and directly observe the activities done at the Health Centre. This helped to confirm the services offered by the Health Centre to the community. The researcher employed non-participant (passive) observation at the Health Centre to systematically document the infrastructure, availability and condition of medical equipment, and the daily activities carried out by health workers, such as patient registration, consultations, laboratory tests, and pharmacy services. Detailed field notes were taken to record both tangible resources and workflow patterns, which enabled verification of information obtained from interviews and questionnaires, ensuring data credibility. Observation provided empirical, context-specific evidence that captures practical realities of service delivery, uncovers gaps between reported and actual practices, and allows triangulation with other data sources to enhance reliability and validity (Creswell & Creswell, 2024; Robson & McCartan, 2022).

3.6 Data Collection Instruments

3.6.1 Questionnaire

The researcher used questionnaire to collect data from community members. The close ended questionnaire was used to collect data for the data. Questionnaires are useful instruments of collecting primary data since respondents can read and then give response to the question and they can reach a large number of subjects (Orodho, 2004). The instrument included items covering four key areas: Planning and Budgeting (8 items), Motivation and Incentives (8 items), Supervision and Feedback (8 items), and Health Service Delivery (8 items). Each set of items was designed to capture perceptions, experiences, and opinions related to the respective dimension, ensuring that quantitative data could be systematically analyzed for trends, relationships, and patterns.

3.6.2 Interview Guide

The Interview guide was prepared by Researcher basing on the Research objectives. This tool allowed the Researcher to obtain in-depth information since there were face to face contact with 1 Municipal health officer, 18 end-users/patients, 3 Health in-charges, 1 Biostatistician, 1 Town clerk, 1 Secretary for social services, 3 Chairperson HUM and 3 Chairperson LC III. The un-structured nature of the guide allowed respondents to elaborate on their experiences, perceptions, and challenges, while maintaining consistency across interviews (Gill et al., 2023; Creswell & Creswell, 2024). The use of interviews was justified because it captured qualitative insights that could not be obtained through questionnaires alone, such as detailed explanations of planning, budgeting, motivation, supervision, and service delivery processes. Furthermore, face-to-face interviews provided opportunities for probing, clarification, and observation of non-verbal cues, enhancing the depth, reliability, and validity of the data collected (Opdenakker, 2022; Brinkmann & Kvale, 2021).

3.6.3 Observation Checklist

The researcher used the checklist to document critical features of the Health Centre, including infrastructure, equipment availability, staff activities, patient interactions, and service delivery processes. The researcher ensured that observations were comprehensive, focused, and aligned

with the research objectives, reducing the risk of missing important information or introducing personal bias (Anguera et al., 2022; Robson & McCartan, 2022). After data collection, the recorded observations were systematically analyzed to identify patterns, verify information obtained through interviews and questionnaires, and provide a detailed understanding of how the Health Centre's resources and operations contributed to service delivery. This method was justified because it enabled the collection of empirical, real-time evidence that complemented other data sources and enhanced the validity and reliability of the study findings.

3.7 Pre-testing

The researcher checked the instruments that were used for data collection to ensure their validity and reliability. This enabled the researcher to check their accuracy and consistency in this research. Vogt (2007) observed that several studies have employed this instrument and established both their validity and reliability to be suitable to the population under the study.

3.7.1 Validity of research Instruments

Validity is defined as the truth or accuracy of the research (Vogt, 2007). Kothari (2008) adds that validity is the criterion which shows the degree which the instrument measure what it is supposed to measure. In order to ensure validity, the researcher ensured that the data collection tools are thoroughly checked by the experts especially the researcher's supervisor to ensure that errors are eliminated. The Content Validity Index (CVI) for every instrument is determined by summing up the number of items rated as valid by expert judge divided by the total number of items in the instrument and on average, it has to be 0.7 and above. The supervisor selected the questions considered to be correct and then after the researcher determined the Content Validity Index using the following formula.

$$\text{Content Validity Index} = \frac{\text{No. of items considered relevant by judge (supervisor for this study)}}{\text{Total number of items rated}}$$

Table 3. 2 Validity analysis

Variables	Items considered	Valid Items	CVI
Planning and budgeting	8	6	0.75
Motivation and incentives	8	7	0.875
Supervision and feedback	8	8	1
Health service delivery	8	7	0.875
Average			0.875

Source: Primary data (2025)

The validity score of 0.875 is true since Amin (2005) suggested that the instrument is valid only and only if it is 70% and above. This implies that the tool was valid once the CVI for each instrument is above 0.7 (Mugenda & Mugenda, 1999).

3.7.2 Reliability of the instruments

Reliability as consistency of either measurement or design to give the same results or conclusions if used at different times by different researchers (Vogt, 2007). The researcher was able to obtain proper values for reliability analysis by use of Statistical Package for version 29 of Social Scientists (SPSS) program. The reliability of the research questionnaire was measured by the help of Cronbach's Alpha Coefficient and the researcher checks if it were greater than 0.7. According to Sekaran, the closer the value of α were to 1, the higher the consistency (Sekaran, 2006). The scores were compared with 0.7 (Drost, 2011). These tools were declared reliable if Cronbach's Alpha Coefficient is greater than 0.7 (Pallant, 2005).

Table 3. 3 Reliability analysis

Variables	Cronbach Alpha
Planning and budgeting	0.831
Motivation and incentives	0.712
Supervision and feedback	0.822
Health service delivery	0.753
Average	0.779

Source: Primary data (2025)

The reliability score was 0.779 which is above 0.7 and suggests that the instrument is reliable (Amin, 2005).

The validity of qualitative research tools (interview guide) were established using a technique known as respondent validation. This basically involves testing of the initial results with the participants in order to see that if the results still ring true. The researcher also triangulated the data to ensure credibility, transferability, dependability and conformability (Torrance, 2012).

3.8 Procedure of Data Collection

The researcher adhered to all necessary procedures for acquiring research clearances and a research permit from the relevant authorities. This process involved obtaining an authorization letter from the Directorate of Graduate Studies, Research, and Innovations at Bishop Stuart University, which allowed the researcher to conduct fieldwork for the study. Ethical guidelines were strictly observed throughout data collection to ensure the rights and welfare of participants were protected. Each data collection tool included an introductory statement requesting respondents' cooperation and explaining the purpose of the study. The informed consent was also obtained from all participants, where they voluntarily agreed to participate after being fully briefed on the study objectives, procedures, potential risks, and their rights to withdraw at any

time without any negative consequences. This ensured that participation was ethical, voluntary, and aligned with standard research ethics protocols (Bryman, 2023; Creswell & Creswell, 2024). Additionally, respondents were informed that the research was purely academic and were assured of the confidentiality of the information they provided, thereby promoting trust and encouraging honest and accurate responses.

3.9 Data Analysis

Data processing consists of two sub-processes: editing and coding. These processes are undertaken to ensure that the gathered data convey logical meaning before being entered into SPSS software version 25 for analysis of the required descriptive statistics. This entailed a thorough examination of completed questionnaires and schedules.

3.9.1 Quantitative 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 were analyzed using descriptive and inferential statistics to derive relevant descriptive statistics (Frequencies, means and percentages) which were additionally analyzed in order to attain relevant conclusions and will

The Pearson correlation coefficient (r) technique was used to determine the strength of the relationships be presented using tables. between two variables that is health unit management committees' planning and budgeting on accessibility of quality health services; health unit management committees' motivation and incentives on health service delivery; health unit management committees' supervision and feedback on health service delivery. The significance of the correlation coefficient is that (i) gives the indication of the magnitude of relationships between two variables; (ii) shows the direction of the relationship between two variables and a positive (+) correlation implies that there is a positive relationship while a negative (-) correlation implies that there is a negative relationship (Mugenda & Mugenda, 2003).

The Regression coefficient (R) was performed in SPSS version 29 to test the hypothesis that is health unit management committees' planning and budgeting on accessibility of quality health

services; health unit management committees' motivation and incentives on health service delivery; health unit management committees' supervision and feedback on health service delivery. The adjusted squared that were used to determine how much variance/changes in the dependent variables were caused by the independent variables. The relationship between the independent variable were established through probability values and the F-statistic at confidence levels of 95%. The F-statistics tells the researcher whether one or more of the independent variables significantly predicts the dependent variable at the selected probability level (Mugenda & Mugenda, 2003).

3.8.2 Qualitative Data analysis

Qualitative data collected using interview guide was analyzed by content analysis using NVIVO software which were done by reading through each transcript carefully to identify and eliminate bias; the transcripts were interpreted by labelling relevant words, phrases, sentences, or sections with codes. The data was further segmented by creating a spreadsheet to easily compile the data and describe the connections between them and finally the segments were analyzed and results were written using verbatim quotes in italics. Nueman (1997) states that content analysis enables the researcher to gather and analyze data in the context of text.

3.9. Ethical Considerations

The researcher assured the respondents of confidentiality of the findings of the study that the research was purely academic. The procedure of acquiring permission and clearance from the Research Ethics Committee (REC) were put into consideration where by research permit were issued to the researcher to conduct the study. The emphasis on ethical considerations for the study enabled the research cooperation of respondents in providing the required data.

The goal of ethics in research is to ensure that no one is harmed or suffers adverse consequences from the research activities (Cooper & Schindler, 2008). Research ethics is critical for all participants, there are a number of ethical issues that researcher must adhere to (Willing & Stainton, 2008). The researcher ensured all these are upheld through the following ways:

Participation in the study was entirely voluntary, and respondents were given the option to either

take part or decline. Each participant had the right to withdraw or discontinue their involvement at any point without any consequences (Christians, 2011). This approach helped to build respondents' confidence in participating. To ensure the collection of accurate and reliable information, the researcher sought to gain maximum cooperation by establishing a friendly and trusting relationship with respondents prior to data collection.

Respondents were guaranteed the right to anonymity, allowing them to withhold any information they considered sensitive or private (Babbie, 2011). To protect their privacy, the researcher did not record participants' names; instead, only relevant demographic details were documented, and in the case of interviews, random code numbers were assigned to each respondent.

To ensure data protection, the researcher clearly explained to participants that the information they provided would be used solely for academic purposes and would not be shared outside the study context. All data were handled with strict confidentiality: responses were recorded using coded identifiers instead of names, digital data were stored on password-protected devices, and physical documents were kept in locked cabinets accessible only to the researcher. Additionally, any reporting of results was done in aggregate form, ensuring that individual responses could not be traced back to specific participants, thereby preventing unauthorized access and safeguarding participants' privacy.

To ensure the study was conducted efficiently and effectively, the researcher obtained a formal letter of introduction from Bishop Stuart University (BSU), which served as official authorization to conduct fieldwork. This letter was presented to respondents prior to interviews and data collection, helping to legitimize the study, build trust, and facilitate cooperation from participants. By showing the letter, the researcher demonstrated that the study was academic in nature and had institutional backing, which also helped in sensitizing respondents about the study objectives and their roles, thereby improving response rates and the quality of data collected (Orodho, 2004; Mugenda & Mugenda, 2003).

3.10 Limitations of the study

Methodological limitations: The study didn't use cross-sectional design meant that data were collected at a single point in time, which limited the ability to capture changes or trends over time. In addition, the study relied heavily on self-reported data, which may have been subject to recall bias or social desirability bias, potentially influencing the accuracy of responses. The relatively limited sample size may also have affected the statistical power of the study and reduced the robustness of the findings.

Contextual limitations: The findings of this study may not be generalizable beyond the specific geographic area and institutions under investigation. Moreover, cultural and socio-economic contexts unique to the study setting may further limit the applicability of the results to other regions or populations.

Data-related limitations: Some of the data collected were incomplete or missing, which may have influenced the analysis and interpretation of results. Additionally, access to secondary data sources was limited, constraining the comprehensiveness and triangulation of the study findings.

Resource and logistical limitations: The study was conducted within tight time constraints, which limited the depth of data collection and analysis. Furthermore, financial constraints restricted the scope of activities, such as expanding the sample size or employing more advanced data collection and analytical techniques.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.0 Introduction

This chapter presents the analysis and interpretations of the study findings arising from the data collected from the respondents using questionnaires and interview guides. The first section presents the response rate and demographic characteristics followed by a presentation and analysis of the study findings in relation to specific objectives. The purpose of the study was to establish the role of Health Unit Management Committees on Health Service delivery in Sheema Municipality, Uganda.

4.1 Response rate

The study considered a sample size of 80 respondents to participate in the questionnaire survey study but only 75 took part where as 13 respondents were targeted in the interview method and took part. The analysis on the response rate is presented in Table 4.1.

Table 4. 1 Response rate

SN	Category	Target sample size	Actual response	Response rate
1	Care takers (Health Centre users/clients/community members).	80	75	93.8%
2	End users/ patients	18	18	100%
3	Municipal health officer	1	1	100%
4	Health in-charges.	3	3	100%
5	Biostatistician	1	1	100%
6	Town clerk	1	1	100%
7	Secretary for social services	1	1	100%
8	Chairperson HUM	1	3	100%
9	Chairperson LC III	3	3	100%
	Total	111	106	95.4%

Source: Primary data (2025)

Table 4.1 shows that out of the 111 targeted respondents, 106 of them participated in the study (95.4%). According to Kombo and Tromp (2009), a response rate of 50% and above is high enough. Furthermore, Taylor-Powell and Hermann (2000) suggest that a response rate of 0.60 (60%) and above is acceptable. According to Mugenda and Mugenda (2009) a response rate of 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent. The high response rate in this study was attributed to; the enthusiasm of the researcher to carry out constant follow-ups on variance of responses.

4.2 Background Characteristics

This section presents facts about the respondents, namely; gender, age category, education levels, marital status and years spent in Health Services in Sheema Municipality. The data on background characteristics of the respondents is indicated in Table 4.2.

Table 4. 2: Respondents Demographic characteristics

Variable	Category	Frequency (f)	Percentage (%)
Gender	Male	42	56.0
	Female	33	44.0
Age	Below 24 years	10	13.3
	25–29 years	15	20.0
	30–34 years	14	18.7
	35–39 years	13	17.3
	40–44 years	12	16.0
	Over 44 years	11	14.7
Education Level	Certificate	12	16.0
	Diploma	18	24.0
	Undergraduate	20	26.7
	Postgraduate	15	20.0
	Others	10	13.3
Years in Health Service	Less than 4 years	16	21.3
	5–9 years	20	26.7
	10–14 years	21	28.0
	Over 14 years	18	24.0

Source: Primary data (2025)

Gender Distribution

Table 4.2 shows that 42 males (56.0%) and 33 females (44.0%). This indicates a slightly higher representation of male respondents in the study, but the sample is relatively balanced. Such distribution suggests that both genders are actively involved in health service management, allowing for diverse perspectives in the assessment of HUMC activities.

Age Distribution

Respondents were distributed across different age groups, with the largest proportion aged 25–29 years (20.0%) and 30–34 years (18.7%). Respondents below 24 years accounted for 13.3%, while those over 44 years represented 14.7%. This age profile indicates a mix of youthful and experienced professionals, suggesting that the study captures perspectives from both emerging and seasoned members of the health workforce.

Educational Level

Regarding education, the majority of respondents held an undergraduate degree (26.7%), followed by diploma holders (24.0%) and postgraduates (20.0%). Certificate holders accounted for 16.0%, and 13.3% had other qualifications. This reflects a generally well-educated sample, which is likely to influence the respondents' understanding of HUMC operations, planning, and decision-making in health service delivery.

Years of Experience in Health Service

Experience in health service varied among respondents, with 28.0% having 10–14 years, 26.7% having 5–9 years, and 24.0% over 14 years. Those with less than 4 years of experience made up 21.3%. This distribution indicates that the study captured insights from both relatively new and highly experienced health professionals, providing a comprehensive understanding of HUMC practices and the accessibility of health services.

4.3 Results on health service delivery among Health centres

The question items on the same were measured using the scale where 1 = Strongly Disagree (SD), 2 = Disagree (D), 3 = Neutral (N), 4 = Agree (A), and 5 = Strongly Agree (SA). In this

study, analysis was done cumulatively with “strongly Agree” and “Agree” were aggregated to mean agreement, Neutral remained the same, “Strongly disagree” and “disagree” were aggregated to indicate disagreement. Means were also used to analyse the data with a mean above 3 indicates an agreement of respondents, a mean of 3 shows un decided and a mean below 3 shows disagreement by respondents. The results are presented in Table 4.3.

Table 4. 3 Accessibility of Health Service delivery (N = 75)

No.	Statement	1 (SD) f (%)	2 (D) f (%)	3 (N) f (%)	4 (A) f (%)	5 (SA) f (%)	Mean
1	The health facility accounts properly for all resources received.	5 (6.7%)	9 (12.0%)	12 (16.0%)	28 (37.3%)	21 (28.0%)	3.68
2	Health workers at the facility perform their duties effectively.	4 (5.3%)	8 (10.7%)	11 (14.7%)	30 (40.0%)	22 (29.3%)	3.78
3	There has been a reduction in unnecessary patient referrals.	6 (8.0%)	12 (16.0%)	13 (17.3%)	26 (34.7%)	18 (24.0%)	3.51
4	The facility is adequately equipped with essential medical equipment.	9 (12.0%)	13 (17.3%)	14 (18.7%)	25 (33.3%)	14 (18.7%)	3.29
5	Citizens are generally satisfied with the services offered at the facility.	5 (6.7%)	9 (12.0%)	13 (17.3%)	28 (37.3%)	20 (26.7%)	3.65
6	Drugs and medical supplies are delivered on time.	8 (10.7%)	11 (14.7%)	12 (16.0%)	27 (36.0%)	17 (22.7%)	3.46
7	All community members, regardless of location or status, can access services equitably.	6 (8.0%)	10 (13.3%)	14 (18.7%)	27 (36.0%)	18 (24.0%)	3.55
8	Quality health services are consistently available to patients in need.	5 (6.7%)	9 (12.0%)	12 (16.0%)	29 (38.7%)	20 (26.7%)	3.67

Source: Primary data (2025)

The health facility accounts properly for all resources received.

Table 4.3 shows that mean of 3.68 indicate majority of the respondents agree with health facility accounts properly for all resources received. With 65.3% agreed most respondents perceive that

resources are properly managed. However, 18.7% of respondents disagreed or strongly disagreed, suggesting occasional lapses in resource accounting that may require attention.

Respondents highlighted that proper accounting strengthens transparency and ensures efficient use of resources.

One participant explained;

“We keep detailed records of all supplies, funds, and equipment that come to the facility. During audits and supervision, we can easily show how resources were used, which builds trust with the community and the district authorities” (Key Informant D male aged 38).

This implies that proper resource accounting promotes transparency, accountability, and effective utilization of health facility resources, which ultimately supports improved service delivery and community trust.

However Key Informant E male aged 40 on 10th September 2025 added;

"There are times when reporting delays or high patient loads make it difficult to update all records on time, and occasionally some resources are not properly documented. This can lead to misunderstandings during audits and may reduce community confidence in how the facility manages its resources" (Key Informant E male aged 40).

This implies that even occasional lapses in resource accounting can undermine transparency and accountability, potentially eroding community trust and confidence in the health facility.

Health workers at the facility perform their duties effectively.

This item received a mean of 3.78, the highest among several statements, reflecting a strong positive perception of staff performance. 69.3% agreed while 16.0% disagreed. This indicates that most respondents consider health workers to be competent and diligent in delivering services.

One participant explained;

“Most of the health workers are committed and follow the procedures properly. They attend to patients on time, maintain records accurately, and provide health education during consultations. Their dedication has noticeably improved the quality of care in our community” (Key Informant K male aged 49 on 10th September 2025).

This implies that effective performance by health workers enhances service quality, patient satisfaction, and overall health outcomes, reinforcing the importance of skilled and motivated staff in facility operations.

Key Informant L had this to say;

"Although most health workers are dedicated, there are occasional delays in attending to patients during peak hours, and some staff members are overwhelmed by the workload. This sometimes affects the timeliness and consistency of service delivery" (Key Informant L male aged 18 on 10th September 2025).

This implies that workload pressures and occasional inefficiencies can reduce the overall effectiveness of health service delivery, potentially affecting patient satisfaction and health outcomes.

There has been a reduction in unnecessary patient referrals.

The mean score of 3.51 reflects a moderate positive perception. 68% agreed that unnecessary referrals have decreased whereas 24.0% disagreed or strongly disagreed. This suggests that while referral practices have improved, some facilities may still experience inefficiencies in patient management.

Respondents noted that proper supervision and guidance by the HUMC have improved decision-making at the facility level. One participant explained;

“With regular supervision and feedback from the HUMC, our staff now manage most cases at the facility without sending patients elsewhere unnecessarily. This has reduced delays in care and helped patients receive timely treatment” (Key Informant D male aged 38 on 10th September 2025).

This implies that reducing unnecessary referrals improves health service efficiency, ensures timely care for patients, and optimizes the use of available resources at the health facility.

Key Informant B, female, aged 42 had this to say;

"Despite improvements, there are still instances where patients are referred unnecessarily due to lack of certain equipment, limited staff expertise, or uncertainty in diagnosis. This sometimes delays treatment and increases the burden on higher-level facilities" (Key Informant B, female, aged 42 on 10th September 2025).

This implies that while HUMC supervision has improved referral practices, remaining inefficiencies can compromise timely care and overburden referral facilities.

The facility is adequately equipped with essential medical equipment.

With the lowest mean of 3.29, this statement shows that average of respondents agreed. It is noted that 33.3% agreed while 29.3% disagreed. This suggests that inadequate medical equipment remains a challenge, potentially limiting the quality and efficiency of health service delivery. Respondents emphasized that having the necessary equipment enables health workers to provide timely and quality care. One participant explained, *"Our facility has most of the essential equipment, like blood pressure machines, delivery kits, and basic laboratory tools. This allows us to diagnose and treat patients efficiently without having to refer them unnecessarily"* (Key Informant H male aged 44). This implies that adequate medical equipment supports effective service delivery, reduces unnecessary referrals, and enhances patient care quality.

It is also noted that;

"Despite having some essential equipment, there are times when key machines or supplies are unavailable or malfunctioning. This forces staff to delay treatment or refer patients to other facilities, which affects the timeliness and quality of care" (Key Informant F male aged 43 on 10th September 2025).

This implies that insufficient or malfunctioning medical equipment can compromise health service delivery, leading to delays, unnecessary referrals, and reduced patient satisfaction.

Addressing equipment gaps through regular maintenance, timely replacement, and adequate supply management is critical to ensure consistent, high-quality care and optimize the effectiveness of health facility services.

Citizens are generally satisfied with the services offered at the facility

The mean of 3.65 indicates a positive perception of patient satisfaction. 63.7% agreed that citizens are satisfied, while 18.7% disagreed. This implies that while most community members are content with the services, some may still encounter issues affecting satisfaction, such as waiting times or service quality.

One participant explained, *“Most people in the community say they are happy with the services here. The health workers are helpful, medicines are usually available, and patients are attended to promptly. People feel comfortable coming here for care”* (Key Informant A male aged 40 on 10th September 2025).

This implies that high levels of citizen satisfaction reflect the facility’s effectiveness in meeting community health needs and indicate that health service delivery is responsive, accessible, and trusted by the population.

However;

"Although many citizens are satisfied, some still report long waiting times, occasional stock-outs of medicines, or delays in attending to patients, which can reduce their overall confidence in the facility" (Key Informant D female aged 47 on 10th September 2025).

The implies that while general satisfaction is high, service delivery challenges such as delays and shortages can negatively affect patient experience and trust.

Drugs and medical supplies are delivered on time.

This item scored a mean of 3.46, shows that average of the respondent’s agreed. It is also noted that 58.7% agreed that deliveries are timely, whereas 25.4% disagreed or strongly disagreed. This highlights occasional delays in drug and supply delivery, which could affect patient care and service continuity.

Respondents highlighted that timely delivery is critical for uninterrupted health services. One participant explained;

“The district has been consistent in delivering essential medicines and supplies on schedule. This allows us to provide continuous care to patients without interruptions. For instance, we rarely face stock-outs of critical drugs like malaria treatments or antibiotics, which used to be a big problem. Because supplies arrive on time, health workers can plan their work effectively, patients receive timely treatment, and community trust in the facility has improved significantly” (Key Informant B male aged 40 on 10th September 2025).

This implies that timely and reliable delivery of drugs and medical supplies strengthens service continuity, improves patient outcomes, and enhances the credibility and efficiency of the health facility.

However;

"Although deliveries are generally on schedule, there are occasional delays due to transportation challenges or administrative bottlenecks. When this happens, some essential drugs run out, and patients may experience delays in receiving treatment" (Key Informant G, female, aged 42 on 10th September 2025).

This implies that even occasional delays in drug and medical supply deliveries can disrupt service continuity, compromise patient care, and reduce community trust in the facility.

All community members, regardless of location or status, can access services equitably.

The mean of 3.55 indicates a moderate positive perception of equitable access. 60% agreed that services are accessible to all, while 21.3% disagreed. This suggests that while equity is largely achieved, geographic or socioeconomic barriers may still limit access for some community members.

Respondents highlighted that the facility actively ensures fairness in service provision. One participant explained;

“We make it a priority that every person who comes to the facility receives the same attention and care, whether they are from the town center or a distant village. No one is turned away or treated differently because of their social status, income, or background. Even during busy days, we organize patients in a way that everyone is attended to promptly. This approach has helped build trust in the community, and people feel confident that they will be treated fairly whenever they seek care” (Key Informant F male aged 43 on 10th September 2025).

This implies that equitable access strengthens community trust, promotes inclusivity, and ensures that health services reach all individuals, thereby improving overall health outcomes and social cohesion.

Quality health services are consistently available to patients in need.

This item received a mean of 3.67, reflect a generally positive perception of service consistency. It is noted that 64.7% agreed, while 18.7% disagreed. This suggests that while quality services are mostly reliable, occasional gaps in availability may occur, possibly due to resource or staffing constraints.

Respondents emphasized that the facility reliably provides essential services, ensuring patients receive timely and effective care. One participant explained;

“Patients can always expect to receive the services they need when they come to the facility. The staff follow proper procedures, essential medicines are usually in stock, and diagnostic services are available. Even during busy periods, the facility prioritizes patient care and ensures no one is turned away. This consistency has improved health outcomes and strengthened the community’s confidence in the services we provide” (Key Informant B male aged 44 on 10th September 2025).

This implies that consistent availability of quality services enhances patient trust, ensures timely treatment, and contributes to better health outcomes in the community.

However;

"Despite generally consistent services, there are times when certain essential services or diagnostic tests are unavailable due to equipment failure or staff shortages. This can lead to delays in treatment and occasional patient dissatisfaction" (Key Informant G, female, aged 42).

This implies that even occasional gaps in service availability can affect patient trust, delay care, and potentially impact health outcomes.

4.4 Descriptive statistics for effect of health unit management committees' planning and budgeting on accessibility of quality health services

The study aimed at determining the effect of health unit management committees' planning and budgeting on accessibility of quality health services. 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 Health unit management committees’ planning and budgeting on accessibility of quality health services (N = 75)

No .	Statement	1 (SD) f (%)	2 (D) f (%)	3 (N) f (%)	4 (A) f (%)	5 (SA) f (%)	Mean
1	The HUMC actively participates in mobilizing resources for the health facility.	5 (6.7%)	8 (10.7%)	12 (16.0%)	30 (40.0%)	20 (26.7%)	3.70
2	The committee effectively identifies funding gaps and seeks support from stakeholders.	4 (5.3%)	10 (13.3%)	15 (20.0%)	28 (37.3%)	18 (24.0%)	3.62
3	Budget allocations made by the HUMC reflect priority health needs of the community.	6 (8.0%)	9 (12.0%)	10 (13.3%)	32 (42.7%)	18 (24.0%)	3.63
4	HUMC meetings on planning and budgeting are conducted transparently.	7 (9.3%)	11 (14.7%)	12 (16.0%)	29 (38.7%)	16 (21.3%)	3.48
5	The HUMC shares financial reports with stakeholders to promote accountability.	8 (10.7%)	9 (12.0%)	13 (17.3%)	27 (36.0%)	18 (24.0%)	3.51
6	Clear guidelines are followed by the HUMC to control and monitor expenditure.	5 (6.7%)	12 (16.0%)	14 (18.7%)	28 (37.3%)	16 (21.3%)	3.50
7	Planning and budgeting involve input from health workers and community members.	4 (5.3%)	7 (9.3%)	15 (20.0%)	31 (41.3%)	18 (24.0%)	3.70
8	Financial control measures implemented by the HUMC enhance service delivery efficiency.	6 (8.0%)	10 (13.3%)	11 (14.7%)	30 (40.0%)	18 (24.0%)	3.58

Source: Primary data (2025)

The HUMC actively participates in mobilizing resources for the health facility.

The Table 4.4 shows that most respondents agreed that the HUMC actively mobilizes resources, with 66.7% Agreed and 16.7% disagreed. The mean score of 3.70 indicates a generally positive perception. This suggests that resource mobilization is a key activity of HUMCs and is recognized by the majority of respondents as contributing to the operational capacity of the health facility.

“The committee always reaches out to local stakeholders and donors to ensure the facility has enough resources to serve the community highlights the proactive role of HUMCs in resource mobilization (Key Informant F male aged 43 on 10th September 2025).

It emphasizes that the committee does not passively wait for funding but actively engages with external actors to secure financial and material support. This approach ensures that health facilities maintain operational continuity, addressing gaps in essential supplies, equipment, and services. It also reflects strategic collaboration, showing that effective HUMCs build networks with donors, community leaders, and government agencies to strengthen service delivery.

“Without the HUMC’s active fundraising and advocacy, many essential supplies would be lacking at the health center underscores the critical impact of HUMC activities on healthcare accessibility and quality (Key Informant D male aged 38 on 10th September 2025).

This implies that the committee’s work is not merely administrative but directly influences patient care outcomes. HUMCs help prevent stock-outs of medicines, medical supplies, and other essentials, which could otherwise disrupt health services. This perspective reinforces the idea that resource mobilization is central to the committee’s function, ensuring that planning and budgeting efforts translate into tangible improvements in service delivery.

The committee effectively identifies funding gaps and seeks support from stakeholders.

Responses indicate that 37.3% of respondents agreed and 24.0% strongly agreed that HUMCs identify funding gaps and secure stakeholder support, while 5.3% strongly disagreed and 13.3% disagreed. The mean of 3.62 reflects a moderately positive perception. This suggests that while HUMCs are largely effective in identifying financial gaps, there is room to strengthen their engagement with stakeholders for better resource mobilization.

A key informant noted; *“We always review the facility’s financial status and identify areas where funds are lacking. Then we reach out to local government offices, NGOs, and community leaders to fill these gaps so that essential services are not disrupted”* (Key Informant A female aged 32 on 10th September 2025). This statement emphasizes that HUMCs actively monitor financial shortfalls and take deliberate steps to secure support from multiple stakeholders, highlighting their central role in ensuring that health facilities remain functional and responsive to community needs.

Budget allocations made by the HUMC reflect priority health needs of the community.

For this statement, 66.7% agreed while 18.0% disagreed. The mean score of 3.63 indicates that respondents generally believe budget allocations align with community health priorities. This demonstrates that HUMCs are largely responsive to community needs in their budgeting decisions, although some respondents perceive occasional misalignment.

“When we prepare the budget, we first consult with health workers and community representatives to understand the most pressing needs. This ensures that the funds we allocate address actual health priorities, like maternal care and essential medicines” (Key Informant F female aged 52 on 10th September 2025).

This highlights that HUMCs take a participatory approach, integrating community and staff input to align budgeting with real needs.

“Our budget meetings always focus on what the community requires most. For example, if there is a shortage of drugs or medical equipment, we prioritize those areas before anything else” (Key Informant B male aged 44 on 10th September 2025).

This underscores the committee's commitment to responsive planning and shows that budgeting decisions are grounded in improving service delivery based on community priorities.

HUMC meetings on planning and budgeting are conducted transparently.

Transparency in HUMC meetings received a mean of 3.48, slightly lower than other items. While 60.0% agreed and 24.0% disagreed. This suggests that while most respondents perceive meetings as transparent, there remains a moderate level of concern regarding openness and clarity in decision-making processes. Enhancing transparency could further strengthen community trust in the committees.

“All planning and budgeting meetings are open to health workers and community representatives. We share the proposed budgets, discuss priorities, and document every decision so that everyone knows how resources will be used” (Key Informant B male aged 40 on 10th September 2025).

This emphasizes that transparency is embedded in HUMC operations, ensuring accountability and fostering trust among stakeholders.

“We circulate financial reports and hold follow-up discussions with the community and facility staff. This way, no one feels left out, and everyone understands how and why budget decisions are made” (Key Informant A female aged 44 on 10th September 2025).

This highlights that the committee actively involves stakeholders, promoting participatory decision-making and reinforcing the integrity of the budgeting process.

The HUMC shares financial reports with stakeholders to promote accountability

The mean of 3.51 indicates a positive but moderate perception. About 60.0% agreed that financial reports are shared, while 22.7% disagreed. This shows that while financial accountability mechanisms exist, some respondents feel that reporting could be more consistent or accessible to stakeholders, highlighting an area for improvement in accountability practices.

“After every budgeting cycle, we prepare and share financial reports with the health facility staff, local leaders, and sometimes even community gatherings. This keeps

everyone updated on how funds were spent” (Key Informant F male aged 48 on 10th September 2025).

This highlights the HUMC’s deliberate effort to promote accountability and openness in financial management. Therefore, circulating reports to both technical staff and community representatives, the committee creates a transparent environment where resource allocation decisions are visible to all stakeholders.

However;

"Although we share financial reports, there are times when not all stakeholders receive them promptly, and some community members find the reports difficult to understand. This sometimes limits the effectiveness of accountability efforts" (Key Informant G, female, aged 42 on 10th September 2025).

This implies that while HUMCs make deliberate efforts to promote financial accountability, inconsistent dissemination and limited accessibility of reports can reduce transparency and stakeholder engagement.

Clear guidelines are followed by the HUMC to control and monitor expenditure.

Responses indicate a mean of 3.50, with 58.7% agreed. A combined 22.7% of respondents disagreed show some inconsistencies in guideline adherence. This implies that HUMCs generally implement expenditure control measures but may face challenges in uniform compliance, which could affect the efficiency of resource utilization. A key informant shared;

“We follow clear financial management guidelines provided by the district and the Ministry of Health, which help us track and control every expenditure made at the facility” (Key Informant F male aged 48 on 10th September 2025).

This shows that HUMCs rely on structured frameworks to ensure funds are managed systematically and in line with policy requirements.

However;

"Sometimes, due to workload pressures or limited understanding among new committee members, not all expenditures are recorded or monitored promptly, which can lead to minor inconsistencies in following the guidelines" (Key Informant H, female, aged 46).

This implies that while HUMCs generally follow established guidelines for expenditure control, occasional lapses can compromise the efficiency and transparency of resource utilization.

Planning and budgeting involve input from health workers and community members.

This statement received a mean of 3.70, with 65.3% agreed 14.6% of respondents disagreed. This indicates that HUMCs are perceived as inclusive in their planning processes, ensuring that the perspectives of both health workers and community members are considered in budgeting and planning decisions, which likely enhances relevance and effectiveness.

“Before finalizing any budget, we consult both health workers and community representatives. Their input helps us understand what services are most needed and ensures that our planning reflects real community priorities” (Key Informant D male aged 38 on 10th September 2025).

This underscores that the HUMC adopts a participatory approach, valuing insights from both staff and beneficiaries to make informed budgeting decisions.

“We hold meetings where everyone, from nurses to local council members can voice their concerns and suggestions. This collaboration ensures that the resources are directed to areas that truly impact service delivery” (Key Informant J male aged 53 on 10th September 2025).

This highlights that inclusion of stakeholders is systematic, reinforcing accountability and enhancing the relevance of the planning process.

However, part:

“Although we strive for inclusive planning, there are occasions when not all community members or health workers are able to attend meetings, which sometimes limits the diversity of input and may affect how well the budget addresses all needs” (Key Informant G, male, aged 45 on 10th September 2025).

This implies that while HUMCs generally follow a participatory approach in planning and budgeting, occasional gaps in stakeholder involvement can reduce the comprehensiveness and effectiveness of decisions.

Financial control measures implemented by the HUMC enhance service delivery efficiency.

The mean of 3.58 suggests a generally positive perception of financial control measures. With 64.0% agree most respondents believe that these measures improve efficiency while 21.3% expressed some disagreement. This reflects that while financial controls are largely effective, there may be gaps in monitoring or enforcement that, if addressed, could further improve service delivery outcomes.

Qualitatively; Key Informant A male aged 45 noted that When the committee enforces financial controls such as budget approvals and expenditure tracking, services run smoothly because the facility avoids shortages and unnecessary delays”.

This highlights that effective financial oversight not only enhances accountability but also ensures continuity of essential services.

However, part:

"Although financial controls are generally followed, there are instances where monitoring is delayed or some expenditures are not fully tracked, which can occasionally slow down service delivery or cause minor resource shortages" (Key Informant B, female, aged 42).

This implies that while HUMC financial control measures largely enhance service delivery efficiency, gaps in monitoring and enforcement can reduce their effectiveness.

4.4.1 Correlation between health unit management committees’ planning and budgeting on accessibility of quality health services

The study was conducted find out whether there was any relationship between health unit management committees’ planning and budgeting on accessibility of quality health services. The

analysis was done using Pearson correlation coefficient. The elicited response was presented in Table 4.5.

Table 4. 5 Pearson correlation results of health unit management committees’ planning and budgeting on accessibility of quality health services (n=75)

		Health unit management committees’ planning	Health service delivery
Health unit management committees’ planning	Pearson Correlation	1	.536**
	Sig. (2-tailed)		.000
	N	75	75
Health service delivery	Pearson Correlation	.536**	1
	Sig. (2-tailed)	.000	
	N	75	75
** Correlation is Significant at the 0.01 (2-tailed) ** Correlation is significant at the 0.05 (1-tailed)			

Source: Primary data (2025)

Table 4.5 shows that Health unit management committees’ planning had a positive significant contribution with health service delivery since p-value is less than 0.05. The Pearson correlation coefficient ($r=.536$) shows that there is a positive significant contribution of Health unit management committees’ planning on health service delivery. This implies that any positive change in health unit management committees’ planning results in to a positive change in health service delivery. This implies that government and municipal health authorities should prioritize capacity-building, training, and resource support for HUMCs to strengthen their planning

functions, ensuring that health services are effectively aligned with community needs and national health objectives.

4.5 Descriptive statistics for influence of health unit management committees' motivation and incentives on health service delivery.

The study aimed at determining the influence of health unit management committees' motivation and incentives on health service delivery in Sheema Municipality, Uganda. 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 as presented in Table 4.6.

Table 4.6 Descriptive statistics of influence of health unit management committees' motivation and incentives on health service delivery (N = 75).

No.	Statement	1 (SD) (%)	2 (D) f (%)	3 (N) f (%)	4 (A) f (%)	5 (SA) f (%)	Mean
1	Members of the HUMC receive non-financial rewards (certificates) for their service.	10 (13.3%)	12 (16.0%)	15 (20.0%)	23 (30.7%)	15 (20.0%)	3.28
2	The HUMC receives regular feedback and appreciation from the community or local government.	7 (9.3%)	10 (13.3%)	14 (18.7%)	25 (33.3%)	19 (25.3%)	3.52
3	Adequate training is provided to HUMC members to improve their performance.	6 (8.0%)	11 (14.7%)	12 (16.0%)	28 (37.3%)	18 (24.0%)	3.55
4	Capacity-building workshops for HUMCs are regularly conducted by the district or partners.	8 (10.7%)	12 (16.0%)	13 (17.3%)	27 (36.0%)	15 (20.0%)	3.38
5	Motivated HUMC members contribute more actively to health service delivery improvements.	4 (5.3%)	6 (8.0%)	10 (13.3%)	30 (40.0%)	25 (33.3%)	3.88
6	Recognition of HUMC efforts influences their level of commitment and oversight.	5 (6.7%)	8 (10.7%)	12 (16.0%)	28 (37.3%)	22 (29.3%)	3.72
7	The HUMC has access to continuous learning and mentoring opportunities.	7 (9.3%)	11 (14.7%)	14 (18.7%)	27 (36.0%)	16 (21.3%)	3.45

8	Incentive structures (monetary or non-monetary) are well-defined for the HUMC members.	9 (12.0%)	13 (17.3%)	14 (18.7%)	25 (33.3%)	14 (18.7%)	3.29
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Source: Primary data (2025)

Members of the HUMC receive non-financial rewards (certificates) for their service.

Table 4.6 shows that the mean score of 3.28 indicates a moderate perception of non-financial rewards. While 50.7% agreed that HUMC members receive certificates for their service, a substantial proportion (29.3% disagreed) perceived this incentive as inadequate. This suggests that although recognition exists, many members may feel that non-financial rewards are insufficient or inconsistently provided.

Another informant explained, *“Sometimes, recognition matters more than money. When the district awards us certificates, it encourages us to keep volunteering and supporting the facility”* (Key Informant D female aged 47 on 10th September 2025).

This suggests that non-monetary incentives strengthen commitment by validating the sacrifices members make despite limited financial benefits. However, some respondents observed that such rewards are irregular and may not fully address motivation gaps.

As one informant put it, *“Certificates are good, but they are not enough. More consistent recognition and support would help sustain our dedication”* (Key Informant H male aged 44 on 10th September 2025).

This reflects the need for HUMCs to balance symbolic rewards with more substantive support to maintain long-term engagement.

Overall, the qualitative findings reveal that certificates and other forms of non-financial recognition foster pride, visibility, and morale among HUMC members, though their effectiveness could be enhanced if complemented by regular and broader forms of incentives.

The HUMC receives regular feedback and appreciation from the community or local government.

With a mean of 3.52, most respondents positively perceived that HUMCs receive feedback and

appreciation. Specifically, 58.6% agreed and 22.6% disagreed. This indicates that regular feedback mechanisms are somewhat effective, helping members feel acknowledged, although there is room to improve consistency and visibility of appreciation.

Key informants emphasized that regular feedback and appreciation from the community and local government play a critical role in sustaining the morale of HUMC members.

Focus Group discussion explained;

“Whenever we mobilize resources or solve a health facility challenge, the community appreciates our efforts through thank-you messages in meetings or even simple visits to express gratitude” (Key Informant B male aged 52 on 10th September 2025).

This recognition reinforces the committee’s sense of responsibility and strengthens the bond between the HUMC and the community it serves.

Similarly, local government officials have also been a source of appreciation and encouragement. As another informant noted;

“The district health office often gives us feedback on our reports and thanks us for the work done, which motivates us to continue improving service delivery” (Key Informant C male aged 52 on 10th September 2025).

However, some HUMC members felt that this appreciation was inconsistent and sometimes limited to formal events. One explained, *“We mostly hear words of appreciation during annual review meetings, but regular engagement from the community or district would make us feel more supported”* (Key Informant H male aged 52). This highlights the need for structured and frequent feedback mechanisms to sustain motivation and responsiveness. Overall, the qualitative evidence suggests that while HUMCs do receive appreciation from both the community and local government, strengthening the consistency and channels of feedback could further enhance their performance and commitment to health facility governance.

Adequate training is provided to HUMC members to improve their performance.

The mean score of 3.55 suggests a generally positive perception regarding training. Most respondents (61.3% agreed) believe that training enhances performance, while 22.7% disagreed. This implies that while training opportunities exist, some members may feel the training is insufficient in frequency, depth, or relevance to support their roles effectively. Key informants emphasized that adequate training is essential for HUMC members to perform their roles effectively.

One respondent explained, *“The training we receive equips us with the skills to manage budgets, supervise health services, and engage the community effectively. Without it, we would struggle to perform our roles properly”* (Key Informant J male aged 51 on 10th September 2025). This highlights that structured capacity-building improves members’ technical competence and enables them to contribute meaningfully to health service governance.

Another informant noted, *“Capacity-building sessions have improved my understanding of health facility management and decision-making. They make it easier to identify problems and implement solutions that benefit patients”* (Key Informant K female aged 48 on 10th September 2025).

This demonstrates that training enhances practical knowledge and fosters confidence among HUMC members, allowing them to implement effective oversight, planning, and monitoring processes.

However;

“Even though training is provided, some sessions are infrequent or too general, leaving certain members unsure about complex budgeting or monitoring tasks. This sometimes limits our ability to fully perform our responsibilities” (Key Informant L, male, aged 46 on 10th September 2025).

This implies that while training enhances HUMC members’ capacity and confidence, gaps in the frequency, depth, or relevance of training can reduce its effectiveness.

Overall, the qualitative findings indicate that training strengthens HUMC members' capacity, improves accountability, and ensures that planning and supervision activities are carried out in line with best practices.

Capacity-building workshops for HUMCs are regularly conducted by the district or partners.

This item received a mean of 3.38, indicating a moderate perception. Though 56.0% agreed that workshops are regularly conducted, 26.7% disagreed. This suggests that capacity-building efforts are present but inconsistent, and some members may not have regular access to workshops or training events.

Key informants highlighted that regular capacity-building workshops are crucial in enhancing HUMC members' effectiveness. One informant explained, "*The district organizes workshops where we learn about planning, budgeting, and supervision. These sessions keep us updated on policies and best practices*" (Key Informant K female aged 55 on 10th September 2025). This indicates that structured training sessions provide members with the knowledge and skills necessary to manage health facilities efficiently.

However, some participants observed that workshops are sometimes irregular or limited by resources. One explained, "*We wish the workshops were more frequent so we can continuously improve our skills and respond better to community health needs*" (Key Informant L male aged 48 on 10th September 2025). This highlights the need for consistent and sustained capacity-building initiatives to maintain high levels of competence and motivation.

Overall, the qualitative evidence suggests that regular capacity-building workshops enhance HUMC members' knowledge, skills, and collaboration, thereby improving governance and the quality of health service delivery.

Motivated HUMC members contribute more actively to health service delivery improvements.

With the highest mean score of 3.88, this item reflects a strong positive perception. It is noted

that 73.3% agreed that motivation translates into active contribution and 13.3% disagreed. This shows that motivation, whether intrinsic or extrinsic, significantly drives active participation and service improvement among HUMC members. As one participant explained, *“When we are encouraged and recognized, we dedicate more time to following up on health facility issues and mobilizing the community to use services”* (Key Informant L, male, aged 46 on 10th September 2025). Another added, *“Motivation makes us work harder; we feel responsible to monitor service delivery and share feedback with both the health workers and the community”* (Key Informant D male aged 38 on 10th September 2025). These insights demonstrate that motivation directly translates into greater involvement, accountability, and a stronger sense of ownership in improving health service delivery.

Recognition of HUMC efforts influences their level of commitment and oversight.

The mean of 3.72 indicates that respondents perceive recognition as an important factor influencing commitment. It is noted that 66.3% agreed while 17.4% disagreed. This suggests that formal recognition mechanisms enhance accountability and dedication, but gaps in recognition may limit maximum engagement.

As one respondent noted, *“When our work is recognized by the health facility and the community, we feel valued and we put in extra effort to monitor services effectively”* (Key Informant B male aged 40 on 10th September 2025).

Another participant added, *“Sometimes we work hard, but without recognition, members lose morale and attend fewer meetings”* (Key Informant F male aged 48 on 10th September 2025).

These views underscore that recognition not only sustains commitment but also motivates HUMC members to strengthen their oversight roles in health service delivery.

The HUMC has access to continuous learning and mentoring opportunities.

This item scored a mean of 3.45, reflecting a moderate-positive perception. While 57.3% agreed and 24.0% of respondents disagreed. This suggests that continuous learning and mentorship exist

but may not be evenly accessible or structured, which could hinder professional development and performance consistency. As one respondent explained, *“We sometimes receive guidance from district health officials, but the support is not regular, and some members miss out on important updates”* (Respondent 9). This implies that irregular mentoring opportunities can create knowledge gaps among members, leading to inconsistent performance and weakening the overall governance role of HUMCs in health service delivery.

However;

"Although there are opportunities for mentoring, they are often irregular and unstructured. Some members rarely receive guidance, which makes it difficult to stay updated on best practices or new policies" (Key Informant B male aged 40 on 10th September 2025).

This implies that while continuous learning and mentoring can enhance HUMC members' skills and performance, irregular or inconsistent access may create knowledge gaps, reduce effectiveness, and weaken oversight and governance of health service delivery.

Incentive structures (monetary or non-monetary) are well-defined for the HUMC members.

With the lowest mean of 3.29, this item indicates that respondents perceive incentive structures as weak or unclear. Only 33.3% agreed that incentives are well-defined, whereas 29.3% disagreed or strongly disagreed. This highlights a need for clear, structured incentive mechanisms to motivate and sustain member participation and performance. As one respondent stated, *“Sometimes we are promised allowances or recognition, but these do not come consistently, and it discourages members from committing fully”* (Respondent 12). This implies that unclear or irregular incentive structures weaken motivation, reduce commitment, and may contribute to absenteeism, thereby undermining the effectiveness of HUMCs in overseeing health service delivery.

However;

"Even when incentives are provided, they are often delayed or inconsistently applied, leaving some members feeling undervalued and less motivated to participate actively in committee activities" (Key Informant B, female, aged 42 on 10th September 2025).

The implication is that unclear, inconsistent, or delayed incentive structures can reduce HUMC members' motivation, engagement, and commitment, which may compromise effective oversight, planning, and governance of health services.

4.5.1 Correlation between health unit management committees' motivation and incentives on health service delivery.

The study was conducted find out whether there was relationship between health unit management committees' motivation and incentives on health service delivery in Sheema district. The analysis was done using Pearson correlation coefficient. The elicited response was presented in Table 4.7.

Table 4. 7 Pearson correlation results of health unit management committees' motivation and incentives on health service delivery (n=75)

		Health unit management committees' motivation and incentives	Health service delivery
Health unit management committees' motivation and incentives	Pearson Correlation	1	.645**
	Sig. (2-tailed)		.000
	N	75	75
Health service delivery	Pearson Correlation	.645**	1
	Sig. (2-tailed)	.000	
	N	75	75
** Correlation is Significant at the 0.01 (2-tailed)			
** Correlation is significant at the 0.05 (1-tailed)			

Source: Primary data (2025)

The results in Table 4.7 shows that Health unit management committees' motivation and incentives had a positive significant contribution with health service delivery since p-value is less than 0.05. The Pearson correlation coefficient ($r=.645$) shows that there is a positive significant contribution of health unit management committees' motivation and incentives on health service delivery. This implies is that government and municipal health authorities should establish clear, consistent, and well-structured incentive mechanisms both monetary and non-monetary to motivate HUMC members.

4.6 Descriptive statistics for effect of health unit management committees' supervision and feedback on health service delivery

The study aimed at determining the effect of health unit management committees' supervision and feedback on health service delivery. 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 4.8.

Table 4. 8 Showing effect of health unit management committees' supervision and feedback on HUMCs (N = 75)

No.	Statement	1 (SD) f (%)	2 (D) f (%)	3 (N) f (%)	4 (A) f (%)	5 (SA) f (%)	Mean
1	The HUMC conducts regular supervision visits to monitor health facility performance.	6 (8.0%)	9 (12.0%)	11 (14.7%)	28 (37.3%)	21 (28.0%)	3.65
2	Feedback from HUMC supervision is timely and helps address service delivery issues.	5 (6.7%)	8 (10.7%)	12 (16.0%)	29 (38.7%)	21 (28.0%)	3.71
3	The committee documents and shares reports with relevant stakeholders regularly.	7 (9.3%)	10 (13.3%)	13 (17.3%)	27 (36.0%)	18 (24.0%)	3.52
4	The HUMC encourages the sharing of information between health workers and the community.	4 (5.3%)	7 (9.3%)	14 (18.7%)	30 (40.0%)	20 (26.7%)	3.74
5	HUMC interventions have increased community utilization of health services.	6 (8.0%)	9 (12.0%)	12 (16.0%)	28 (37.3%)	20 (26.7%)	3.63
6	Health workers act upon feedback provided by the HUMC to improve services.	5 (6.7%)	10 (13.3%)	13 (17.3%)	27 (36.0%)	20 (26.7%)	3.62
7	The HUMC uses control measures (checklists, tracking tools) during supervision.	6 (8.0%)	11 (14.7%)	12 (16.0%)	28 (37.3%)	18 (24.0%)	3.51
8	Supervision by the HUMC has led to improved quality and accessibility of services.	4 (5.3%)	8 (10.7%)	11 (14.7%)	30 (40.0%)	22 (29.3%)	3.77

Source: Primary data (2025)

The HUMC conducts regular supervision visits to monitor health facility performance.

The mean score of 3.65 indicates a moderately strong positive perception. With 65.3% agreed that most respondents perceive that regular supervision visits are conducted effectively. Only 20.0% disagreed suggesting that while supervision is generally consistent, there may be occasional gaps in frequency or coverage of visits.

As one participant explained, *“We make it a point to visit the health facility regularly to check on the availability of medicines, observe how health workers interact with patients, and ensure that services are delivered according to standards. We also engage with the community to hear their feedback and concerns. After each visit, we compile a report and share it with the district health office. These visits have helped us identify gaps early, address problems promptly, and ensure that the health facility runs smoothly”* (Key Informant F male aged 43 on 10th September 2025). This implies that regular supervision by HUMC members strengthens accountability, promotes timely problem-solving, and enhances the overall quality and responsiveness of health service delivery.

Feedback from HUMC supervision is timely and helps address service delivery issues.

This item has a mean of 3.71, reflecting a positive perception of the timeliness and usefulness of feedback. It is shown that 66.7% agreed that supervision feedback is effective. Still, 17.4% disagreed, indicating that while feedback generally supports improvements in service delivery, some delays or inefficiencies may occasionally occur. One participant explained, *“After our visits, we share detailed feedback with the health workers, highlighting what is working well and what needs attention. Most of the time, they act quickly to fix issues like stock-outs or delays in service provision, which improves patient satisfaction”* (Key Informant G, female, aged 42 on 10th September 2025). This implies that timely feedback from HUMC supervision enhances problem-solving, ensures accountability, and directly contributes to the efficiency and quality of health services delivered to the community.

The committee documents and shares reports with relevant stakeholders regularly.

With a mean of 3.52, respondents perceive documentation and reporting as moderately effective. While 60.0% agreed and 22.6% of respondents disagreed. This indicates that although reporting occurs, some stakeholders may not consistently receive updates, or documentation practices may need strengthening. Respondents indicated that systematic documentation and sharing of reports facilitate transparency and informed decision-making.

One participant explained,

“After each supervision or monitoring activity, we prepare a detailed report outlining our observations, recommendations, and actions taken. These reports are then shared with the district health office, health facility management, and sometimes the community leaders, so everyone is aware of the challenges and progress” (Key Informant D female aged 47 on 10th September 2025).

This implies that regular documentation and reporting promote transparency, enhance accountability, and enable stakeholders to make timely and evidence-based decisions to improve health service delivery.

However:

"Although we document and share reports, sometimes the information does not reach all stakeholders on time, and some reports are not detailed enough for effective decision-making" (Key Informant B, female, aged 42 on 10th September 2025).

This implies that while documentation and reporting promote transparency and accountability, delays or incomplete reporting can limit stakeholder engagement and reduce the effectiveness of oversight.

The HUMC encourages the sharing of information between health workers and the community.

This statement scored a mean of 3.74, the highest among several items. It is noted that 66.7% agreed, indicating that respondents recognize HUMCs as facilitating effective communication. Only 14.6% disagreed, suggesting that information-sharing mechanisms are generally successful

in linking health workers with the community. One participant explained, *“We organize community meetings and health talks where health workers explain the services offered, how to access them, and any new health programs. This way, people are informed, can ask questions, and feel part of the decision-making process”* (Key Informant D female aged 47 on 10th September 2025). This implies that active information sharing strengthens community engagement, increases service utilization, and fosters collaboration between health workers and the community, ultimately enhancing health outcomes.

However;

“Although information-sharing is encouraged, some community members still report not receiving timely updates or being unaware of certain services, which can limit participation and reduce the effectiveness of communication efforts” (Key Informant D, male aged on 10th September 2025).

This implies that while HUMCs largely succeed in facilitating information-sharing, gaps in reach or timeliness can reduce community engagement and hinder optimal service utilization.

HUMC interventions have increased community utilization of health services.

The mean of 3.63 suggests a positive perception of the impact of HUMC interventions. It is noted that 63.7% agreed that supervision has contributed to increased service utilization, while 20.0% disagreed. This implies that supervision activities are largely effective in promoting community engagement, though some respondents feel more improvements are needed.

Health workers act upon feedback provided by the HUMC to improve services.

The mean score of 3.62 reflects a moderately positive perception. 63.7% agreed that health workers respond to feedback, whereas 20.0% disagreed. This indicates that while feedback is generally taken seriously, some health workers may not consistently implement recommendations from HUMC supervision. Respondents noted that constructive feedback from the committee prompts timely corrective actions and enhances service delivery.

One participant explained, *“Whenever we provide feedback after supervision visits, the health workers take it seriously. For example, if we point out medicine stock-outs or*

delays in patient care, they quickly address the issues, ensuring that services run more smoothly and patients are satisfied” (Key Informant D, male aged 38 on 10th September 2025).

This implies that the responsiveness of health workers to HUMC feedback strengthens accountability, improves the quality of services, and fosters a culture of continuous improvement within health facilities.

The HUMC uses control measures (checklists, tracking tools) during supervision.

This item received a mean of 3.51, suggesting a moderate level of implementation of control measures. 61% agreed that checklists and tracking tools are used while 22.7% disagreed. This shows that while control measures exist, their application may not be uniform across all facilities, potentially affecting consistency in supervision quality. Respondents emphasized that structured tools help ensure thorough and consistent monitoring of health facility activities. One participant explained, *“During our supervision visits, we use checklists to track medicine stocks, staff attendance, and service delivery standards. These tools guide our observations and make it easier to identify gaps, which we then report to the district for follow-up”* (Key Informant G, female, aged 42 on 10th September 2025). This implies that the use of structured control measures enhances the accuracy and consistency of supervision, promotes accountability, and facilitates systematic follow-up to improve the quality of health services.

Supervision by the HUMC has led to improved quality and accessibility of services.

With the highest mean of 3.77, respondents generally agree that supervision has a positive impact on service quality and accessibility. 69.3% agreed while only 16.0% disagreed. This suggests that effective supervision by HUMCs is associated with tangible improvements in health service delivery outcomes. Respondents noted that active oversight by the committee directly contributes to better service delivery.

One participant explained, *“Since we started conducting regular supervision visits, we have noticed significant improvements in the health facility. Medicines are more consistently available, staff attend to patients on time, and patients report shorter waiting*

times. During our visits, we identify gaps and work with the facility to address them immediately. Community members have also expressed satisfaction because they feel their concerns are being heard and acted upon” (Key Informant E male aged 40 on 10th September 2025).

This implies that consistent supervision by HUMC members enhances both the quality and accessibility of health services by ensuring timely problem-solving, accountability of health workers, and responsiveness to community needs.

4.6.1 Correlation between health unit management committees’ supervision and feedback on health service delivery

The study was conducted find out whether there was any relationship between health unit management committees’ supervision and feedback on health service delivery in Sheema district. The analysis was done using Pearson correlation coefficient. The elicited response was presented in Table 4.9.

Table 4. 9 Pearson correlation results of health unit management committees’ supervision and feedback on health service delivery (n=75)

		Health unit management committees’ supervision and feedback	Health service delivery
Health unit management committees’ supervision and feedback	Pearson Correlation	1	.702**
	Sig. (2-tailed)		.000
	N	75	75
Health service delivery	Pearson Correlation	.702**	1
	Sig. (2-tailed)	.000	
	N	75	75
** Correlation is Significant at the 0.01 (2-tailed)			
** Correlation is significant at the 0.05 (1-tailed)			

Source: Primary data (2025)

The results in Table 4.9 shows that Health unit management committees' supervision and feedback had a positive significant contribution with health service delivery since p-value is less than 0.05. The Pearson correlation coefficient ($r=.702$) shows that there is a positive significant contribution of Health unit management committees' supervision and feedback on health service delivery. This implies that any positive change in Health unit management committees' supervision and feedback results in to a positive change in health service delivery in Sheema district.

4.7 Verification of the hypothesis testing

The study conducted Analysis of Variance (ANOVA) to examine whether the multiple regression model was fit for the data.

Table 4. 10 Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.827	0.789	0.672	0.854644
a. Predictors: (Constant), Supervision, Motivation, Planning				

The coefficient of determination R^2 value was 0.672. This shows how much of the total variation in the health service delivery was explained by role played by Health Unit Management Committees. Therefore, the study results revealed that Health Unit Management Committees contributes 67.2% to health service delivery in Sheema district. This helped to find out if the role of Health Unit Management Committees can be predicted without relying on the independent variables.

The results of Analysis of Variance (ANOVA) are shown in Table 4.11.

Table 4. 11 ANOVA

ANOVA ^a						
Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	2.214	3	.706	21.680	.000
	Residual	3.802	72	.079		
	Total	6.016	75			
a. Dependent Variable: Health service delivery						
b. Predictors: (Constant), Supervision, Motivation, Planning						

The findings in the Table 4.11, the results show that P-value was $0.000 < 0.05$, implying that the P-value was statistically significant, therefore the overall regression model for roles played by health unit management committees was statistically significant and can be used for prediction purposes at 5% significance level, this further indicate that the variables used in this study are statistically significant.

Table 4. 12 Regression analysis coefficients

Coefficients ^a						
Model		Un standardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.563	.611		4.315	.000
	Planning and budgeting	.352	.183	.451	2.243	.000
	Motivation and incentives	.303	.141	.327	3.232	.000
	Supervision and feedback	.458	.118	.544	2.276	.000
a. Dependent Variable: Health service delivery						

The results in Table 4.12 also show that $\beta = 0.451$ implying that a unit increase in health unit management committees' Planning and budgeting will lead to 0.451 increases in health service

delivery in Sheema district. This is also statistically significant at 95% confidence levels since P-value = 0.00 < 0.05. The first hypothesis “there is a significant influence between revenue planning and health service delivery is accepted.

The results in Table 4.12 also show that $\beta = 0.327$ implying that a unit increase in health unit management committees’ motivation and incentives will lead to 0.327 increases in health service delivery. This is statistically insignificant at 95% confidence levels P-value = 0.000 < 0.05. Therefore, the second hypothesis “health unit management committees’ motivation and incentives has a significant positive influence on the health service delivery” is accepted thus health unit management committees’ motivation and incentives influences the health service delivery.

The results in Table 4.12 also show that $\beta = 0.544$ implying that a unit increase in health unit management committees’ Supervision and feedback will lead to 0.545 increases health service delivery. This is statistically significant at 95% confidence levels since P-value = 0.000 < 0.05. The third hypothesis “health unit management committees’ Supervision and feedback significantly positively influence the health service delivery” is accepted implying health unit management committees’ Supervision and feedback influences on health service delivery.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In this chapter, presents summary of the findings, discussion, conclusion and recommendations. These were based on three specific objectives of the study such as to establish the effect of health unit management committees' planning and budgeting on accessibility of quality health services; to determine the influence of health unit management committees' motivation and incentives on health service delivery and to establish the effect of health unit management committees' supervision and feedback on health service delivery in Sheema Municipality, Uganda.

5.2 Summary of the results

This study was both quantitative and qualitative though the quantitative aspect is more pronounced. The study was designed to establish examine the role of Health Unit Management Committees on Health Service delivery in Sheema Municipality. The key summary of the findings shows that;

5.2.1 Health unit management committees' planning and budgeting on accessibility of quality health services

The study showed that Health unit management committees' planning had a positive significant contribution with health service delivery since p-value is less than 0.05. The Pearson correlation coefficient ($r=0.536$) shows that there is a positive significant contribution of Health unit management committees' planning on health service delivery. This implies that any positive change in health unit management committees' planning results in to a positive change in health service delivery.

The study showed that $\beta = 0.451$ implying that a unit increase in health unit management committees' Planning and budgeting will lead to 0.451 increases in health service delivery in Sheema district. This is also statistically significant at 95% confidence levels since P-value=

0.00<0.05. The first hypothesis “there is a significant influence between revenue planning and health service delivery is accepted.

5.2.2 Health unit management committees’ motivation and incentives on health service delivery

The study showed that Health unit management committees’ motivation and incentives had a positive significant contribution with health service delivery since p-value is less than 0.05. The Pearson correlation coefficient ($r=0.645$) shows that there is a positive significant contribution of health unit management committees’ motivation and incentives on health service delivery.

The study showed that $\beta = 0.327$ implying that a unit increase in health unit management committees’ motivation and incentives will lead to 0.327 increases in health service delivery. This is statistically significant at 95% confidence levels $P\text{-value} = 0.000 < 0.05$. Therefore, the second hypothesis “health unit management committees’ motivation and incentives has a significant positive influence on the health service delivery” is accepted thus health unit management committees’ motivation and incentives influences the health service delivery.

5.2.3 Health unit management committees’ supervision and feedback on health service delivery.

The study showed that Health unit management committees’ supervision and feedback had a positive significant contribution with health service delivery since p-value is less than 0.05. The Pearson correlation coefficient ($r=0.702$) shows that there is a positive significant contribution of Health unit management committees’ supervision and feedback on health service delivery. This implies that any positive change in Health unit management committees’ supervision and feedback results in to a positive change in health service delivery in Sheema district.

The study showed that $\beta = 0.544$ implying that a unit increase in health unit management committees’ Supervision and feedback will lead to 0.545 increases health service delivery. This is statistically significant at 95% confidence levels since $P\text{-value} = 0.000 < 0.05$. The third hypothesis “health unit management committees’ Supervision and feedback significantly

positively influence the health service delivery” is accepted implying health unit management committees’ Supervision and feedback influences on health service delivery.

5.3 Discussion

5.3.1 Health unit management committees’ planning and budgeting on accessibility of quality health services

The study revealed that Health Unit Management Committees’ planning significantly improves health service delivery in Sheema District ($r = .536$, $\beta = 0.451$, $p < 0.05$), thus confirming the first hypothesis. The results are in agreement with Hanif and Musvoto (2022) who found that budgeting processes in many health facilities were characterized by rigidity, delayed fund disbursement, and limited autonomy at the local level. These challenges undermined timely procurement of essential supplies, hindered service planning, and restricted the flexibility needed to respond to emerging health priorities.

The results are in agreement with Muwanguzi et al. (2020) who revealed that when HUMCs were actively engaged in planning processes such as contributing to the development of annual work plans, setting priorities, and participating in resource allocation health facilities demonstrated improved service delivery outcomes. The results are in agreement with MedRxiv Busoga Study (2024) who found a strong positive correlation between the competence of HUMCs in developing and implementing annual work plans and the overall improvement in facility-level health outcomes. The results are in agreement with Tsofa et al. (2021) who revealed that health facilities where HUMCs were involved in regular budget forecasting, monitoring, and mid-year adjustments experienced notable improvements in service delivery outcomes.

The results are in agreement with Kabongo & Mbonigaba (2024) who revealed that health systems characterized by good governance marked by transparency, stakeholder participation, financial accountability, and strategic oversight were more likely to allocate budgets effectively and respond to priority health needs. The results are in agreement with Ntitandekura et al. (2022) who revealed that strict adherence to approved budgets by Health Unit Management Committees

(HUMCs) significantly enhanced the execution of planned activities, particularly in drug procurement, facility maintenance, and community outreach programs.

The results concur with Piatti Fünfkirchen et al. (2020) who found that limited financial autonomy at the local health facility level significantly constrained the ability of Health Unit Management Committees (HUMCs) to plan and respond to community health needs effectively. The results are in line with Gambo et al. (2021) who revealed that effective budgeting facilitates strategic allocation of resources, enabling health management committees including Health Unit Management Committees (HUMCs) to align financial inputs with service delivery goals. The results are in agreement with Er Rays and M'dioud (2024) who demonstrated that health facilities with well-structured financial planning characterized by accurate budgeting, timely allocation, and judicious use of funds were better positioned to deliver high-quality maternal and child healthcare.

5.3.2 Health unit management committees' motivation and incentives on health service delivery

The study found that Health Unit Management Committees' motivation and incentives significantly enhance health service delivery in Sheema District ($r = .645$, $\beta = 0.327$, $p < 0.05$), thereby confirming the second hypothesis. The results are in agreement with Gangu (2021) who found that providing HUMC members with capacity-building workshops significantly improved their understanding of governance roles, financial management, and planning processes.

The results are in agreement with Uganda CHW (2023) who found that providing CHWs with financial rewards such as stipends and transportation reimbursements, alongside non-financial incentives like public recognition, training opportunities, and provision of uniforms, significantly increased their motivation and commitment. The results are in agreement with Dutta (2025) who highlighted that adopting agile methodologies characterized by iterative planning, real-time data utilization, and stakeholder collaboration significantly enhanced project ownership and motivation among health managers.

The results are in agreement with Er-Rays and M'dioud (2024) who revealed that the average technical efficiency score of these hospitals was 0.697, indicating that the facilities were operating at approximately 70% of their potential efficiency. The results are in line with Kabongo and Mbonigaba (2024) who revealed that domestic general government health expenditure (DGGHE) negatively affected disability-adjusted life years (DALY), indicating improved health outcomes. The results are in line with Lutwama et al. (2022) who found that many health supervisors lacked formal training in supportive supervision, which led to challenges in effectively guiding and motivating health workers.

5.3.3 Health unit management committees' supervision and feedback on health service delivery.

The study established that Health Unit Management Committees' supervision and feedback significantly improve health service delivery in Sheema District ($r = .702$, $\beta = 0.544$, $p < 0.05$), thus confirming the third hypothesis.

The results are in line with Dutta (2025) who examined how applying agile, iterative feedback mechanisms in healthcare planning improved resource allocation in Ghana's health system. The study found that by using regular, real-time feedback loops involving stakeholders at various levels, health managers were able to make timely adjustments to budgets and service delivery plans.

The results are in line with Msendma et al. (2021) who studied how supervision focused on data quality within Malawi's Health Management Information System (HMIS) using the DHIS2 platform helped legitimize accurate and timely reporting behaviors among health workers. Their research showed that through mechanisms like mimicking best practices, normative professional standards, and coercive accountability measures, health workers came to view high-quality data management as both a moral and practical responsibility.

The results are in line with Kabongo and Mbonigaba (2024) who investigated how governance influences the effectiveness of public health spending in Sub-Saharan Africa using data from 43 countries between 2013 and 2019. Their study showed that increased government health

expenditure was associated with better health outcomes, measured by reductions in disability-adjusted life years (DALYs).

5.4 Conclusion

5.4.1 Health unit management committees' planning and budgeting on accessibility of quality health services

The study concluded that Health Unit Management Committees' planning has a positive and statistically significant contribution to health service delivery in Sheema District, as evidenced by a Pearson correlation coefficient of $r = .536$ and a regression coefficient of $\beta = 0.451$. This means that any positive change in planning and budgeting by the committees leads to a corresponding improvement in health service delivery. With the p-value (0.00) being less than 0.05 at the 95% confidence level, the first hypothesis that there is a significant influence between revenue planning and health service delivery was accepted.

5.4.2 Health unit management committees' motivation and incentives on health service delivery

The study concluded that Health Unit Management Committees' motivation and incentives have a positive and statistically significant contribution to health service delivery in Sheema District, as indicated by a Pearson correlation coefficient of $r = .645$ and a regression coefficient of $\beta = 0.327$. This implies that a unit increase in motivation and incentives among committee members leads to a 0.327 increase in health service delivery. With the p-value (0.000) being less than 0.05 at the 95% confidence level, the second hypothesis that Health Unit Management Committees' motivation and incentives have a significant positive influence on health service delivery was accepted.

5.4.3 Health unit management committees' supervision and feedback on health service delivery.

The study concluded that Health Unit Management Committees' supervision and feedback have a positive and statistically significant contribution to health service delivery in Sheema District, as shown by a Pearson correlation coefficient of $r = .702$ and a regression coefficient of $\beta =$

0.544. This implies that a unit increase in supervision and feedback leads to a 0.544 improvement in health service delivery. With the p-value (0.000) being less than 0.05 at the 95% confidence level, the third hypothesis that Health Unit Management Committees' supervision and feedback significantly and positively influence health service delivery was accepted.

5.5 Recommendation

5.5.1 Health unit management committees' planning and budgeting on accessibility of quality health services

Based on the finding, is recommended that local governments together with the Ministry of Health and development partners should enhance structured incentive schemes for HUMC members. These could include financial allowances, non-financial rewards such as recognition, certificates of service, and opportunities for capacity-building. Such initiatives would boost morale, strengthen commitment, and encourage members to dedicate their time and skills more effectively toward improving health outcomes in their communities.

5.5.2 Health unit management committees' motivation and incentives on health service delivery.

In addition, continuous and meaningful supervision and feedback mechanisms should enhance accountability and sustained performance of health facilities. Regular supervisory visits, structured reporting frameworks, and timely feedback sessions between HUMCs, health workers, and district health offices would create stronger linkages, enhance responsiveness, and promote a culture of transparency. Encouraging HUMCs to document and share their supervisory findings would also enable better monitoring of service delivery gaps and foster collaborative problem-solving.

5.5.3 Health unit management committees' supervision and feedback on health service delivery.

Ministry of Health should enhance training to HUMCs on effective supervision, leadership, and community engagement strategies. Coupled with adequate logistical support, this would empower them to play a more active oversight role, while their feedback is integrated into

district and national health planning processes. By aligning HUMCs' incentives and supervision functions with broader health system goals, service delivery in Sheema District and similar contexts can be greatly enhanced.

5.6 Contribution of the study to the body of Knowledge

This study makes several contributions to the existing body of knowledge on health service delivery and the role of Health Unit Management Committees (HUMCs) in Uganda and similar contexts. First, it provides empirical evidence that planning, motivation and incentives, and supervision and feedback by HUMCs significantly influence the quality and effectiveness of health service delivery. The findings quantify these relationships using statistical measures such as Pearson correlation coefficients and regression analysis, thereby offering a more precise understanding of the magnitude of influence each factor has on service delivery outcomes.

Second, the study enriches knowledge on the importance of non-financial and financial incentives in sustaining HUMC members' engagement and performance. By demonstrating that motivation and incentives positively impact health service delivery, the study underscores the need for policy frameworks that recognize and support committee members' contributions, filling a gap in prior research that often focused primarily on structural or operational aspects of health systems.

Finally, the research highlights the critical role of supervision and feedback mechanisms in improving accountability and service quality. By showing a strong positive correlation between supervision and health outcomes, this study adds to the theoretical understanding of how active governance and oversight by local health committees can lead to measurable improvements in health facility performance. Overall, the study provides actionable insights for policymakers, health managers, and development partners seeking to enhance community-level health governance and service delivery.

5.7 Areas for further study

Future research could examine the long-term impact of financial and non-financial incentives on HUMC performance, explore the role of community participation in enhancing accountability and service quality, and investigate how HUMCs' planning, motivation, and supervision interact with other health system factors such as resources, staff capacity, and infrastructure.

REFERENCES

- Ackoff, R. L. (1953). *The design of social research*. University of Chicago Press.
- American Hospital Association. (2022). *National Health Care Governance Survey report*.; Joint Commission. (2023). *Refocus your board's attention on quality and patient safety*.
- Atuhaire, L., Nambatya, G., & Kaggwa, E. (2023). Governance and accountability in primary healthcare delivery in Uganda: The role of community health committees. *BMC Health Services Research*, 23(112), 1–10.
- Auditor General. (2024). *Annual report of the Auditor General on the health sector for the financial year 2023/2024*. Office of the Auditor General, Uganda.
- Hanif, R., & Musvoto, T. (2022). Enhancing accountability in health service delivery through community health committees: Evidence from Malawi and Uganda. *Global Public Health*, 17(6), 875–889.
- Ministry of Health (MoH). (2024). *Annual Health Sector Performance Report (AHSPR) FY 2023/2024*. Government of Uganda.
- Nanyonga, J., Kisaakye, P., & Tumushabe, E. (2023). Community participation and health service delivery in Uganda: A case study of Health Unit Management Committees. *African Health Sciences*, 23(2), 156–165.
- ACODE. (2010). *The tragedy of Uganda's health system*. Kampala, Uganda.
- Adi, N. (2012). Driving performance and reflection to employee engagement: A case study in University of Brawijaya. *Journal of Basic and Applied Scientific Research*, 2(6), 1–10.
- Amin, M. E. (2005). *Social science research: Conception, methodology and analysis*. Makerere University.

- Arie, R., Kimani, J., & Wambua, S. (2022). Implementation of program-based budgeting in Kenya's county health systems: Aligning resources with community priorities. *Journal of Health Systems Research*, 7(2), 123-135.
- Bartlett, J. E., Kotlik, J. W., & Higgins, C. C. (2001). Organizational research: Determining appropriate sample size in survey research. *Learning and Performance Journal*, 19, 43–50.
- Bascar, U. C. (2018). Health resources and services administration: What is health centre? Retrieved from <https://bphc.hrs.gov>
- Committee on Economic, Social and Cultural Rights. (2000). *General comment No. 14: The right to the highest attainable standard of health* (UN Doc. E/C.12/2000/4).
- Cooper, D. R., & Schindler, P. S. (2006). *Business research methods* (9th ed.). McGraw-Hill.
- David, J., Zakus, L., & Lysack, C. L. (1998). Revisiting community participation. *Health Policy and Planning*, 13(1), 1–12.
- Daykin, N., & Naido, J. (2005). Feminist critiques of health promotion. In R. Bunton, S. Nettleton, & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, life and risk* (pp. 59–74). Taylor & Francis e-Library.
- Dmytriiev, S. D., & Freeman, R. E. (Eds.). (2023). *R. Edward Freeman's selected works on stakeholder theory and business ethics* (Vol. 53). Springer nature.
- Dutta, P. (2025). Agile planning frameworks and their impact on stakeholder responsiveness and resource allocation in Ghana's primary healthcare system. *International Journal of Health Management*, 10(1), 45-59.
- EA-HPRO. (2017). *Uganda situation analysis report*. Kampala, Uganda.
- Economic Policy Research Centre. (2010). Governing health service delivery in Uganda: A tracking study of drug delivery mechanisms (Research Report 01). Kampala, Uganda.

- El-Jardali, F., Saleh, S., Ataya, N., & Jamal, D. (2011). Design, implementation and scaling up of the balanced scorecard for hospitals in Lebanon: Policy coherence and application. *Health Policy Journal*, 105(2–3), 211–218.
- Engel, J., Glennie, J., Adhikari, S. R., Bhattarai, S. W., Prasai, D. P., & Samuels, F. (2013). *Nepal's story: Understanding improvements in maternal health*. Overseas Development Institute.
- Er-Rays, M., & M'dioud, A. (2024). Financial efficiency and quality of maternal-child health services: Evidence from Morocco's public hospital network. *Health Economics Review*, 14(3), 220-233.
- Family Health Division. (2010). *National female volunteers programme strategy 2067*. Ministry of Health and Population, Kathmandu, Nepal.
- Freeman, R. E., & Greenwood, M. (2020). Deepening methods in business ethics. *Journal of Business Ethics*, 161(1), 1-3.
- Gambo, J., Mwangi, T., & Ochieng, P. (2021). Budgeting as a tool for planning, control, and organizational performance in health organizations: A literature review. *Health Policy and Management Review*, 9(4), 78-91.
- Gangu, D. (2021). Capacity building and performance of Health Unit Management Committees in Uganda: A case study. *BMC Health Services Research*, 21(1), 320.
- Ghuri, P., & Grønhaug, K. (2005). *Research methods in business studies* (3rd ed.). FT Prentice Hall.
- Goodman, C., Opwora, A., Kabare, M., & Molyneux, S. (2011). Health facility committees and facility management. *Bossert and Beauvais Report*, Washington, DC.
- Government of Nepal. (2015). *Nepal health strategy 2015*. Ministry of Health and Population.

- Goyal, L. (2022). Stakeholder theory: Revisiting the origins. *Journal of Public Affairs*, 22(3), e2559.
- Guerzovich, F., & Poli, M. (2020). How social accountability strengthens cross-sector initiatives to deliver quality health services. *Global Partnership for Social Accountability Note*, 2020, 1–17.
- Henrikson, D. K., Peterson, S. S., Waiswa, P., & Fredrickson, M. (2019). Decision-making in district health planning in Uganda: Does use of district-specific evidence matter? *Health Research Policy and Systems*, 17(1), 57.
- International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16), U.N. Doc. A/6316 (1966), art. 25.
- Kabongo, W. N. S., & Mbonigaba, J. (2024). Effectiveness of public health spending: Investigating the moderating role of governance using PLS-SEM. *Health Research Policy and Systems*, 22(1), Article 59. <https://doi.org/10.1186/s12961-024-01159-x>
- Kaim, B., Loewenson, R., & Rusike, I. (2001). *Facilitators guide for meeting to form health centre committees: Guide to the Phase I meeting* (Monograph 4/2001). TARSC & CWGH.
- Kajungu, D., Lukwago, D., & Tumushabe, G. (2015). *Assessing public expenditure governance in Uganda's health sector: The case of Gulu, Kamuli and Luwero Districts* (Policy Research Series No. 69). Kampala, Uganda: ACODE.
- Karuga, R., Kok, M., Luijens, M., Mbindyo, P., & Broerse, J. E. W. (2022). Participation in primary health care through community-level health committees in Sub-Saharan Africa: A qualitative synthesis. *BMC Public Health*, 22, 359.
- Kirkpatrick, I. (2016). Medicine and management in European hospitals: A comparative overview. Retrieved from <https://www.ncbi.nlm.nih.gov>

- Kothari, C. R. (2008). *Research methodology: Methods and techniques* (2nd ed.). New Age International Publishers.
- Lalu, J. A. C. (2024). *An Internal Stakeholder Approach to the Evaluation of Ethical Behaviour in a Scoal Enterprise Hotel* (Doctoral dissertation, University of East London).
- Lieberman, E., & Zhou, Y. Y. (2022). Self-efficacy and citizen engagement in development: Experimental evidence from Tanzania. *Journal of Experimental Political Science*, 9, 46–63.
- Loewenson, R., Machingura, F., & Kaim, B. (2014). *Health centre committees as a vehicle for social participation in health systems in East and Southern Africa* (Discussion Paper No. 101). EQUINET, Harare.
- Ludia, J. M. (2022). Challenges facing health facilities governing committees in ensuring provision of better health services in Tanzania: A case of health centres at Busega District. *Brazilian Benchmarking Journal*, 33(1), 1–63.
- Lugada, E., Komakech, H., Ochola, I., Mwebaze, S., Olowo Oteba, M., & Okidi Ladwar, D. (2022). Health supply chain system in Uganda: current issues, structure, performance, and implications for systems strengthening. *Journal of pharmaceutical policy and practice*, 15(1), 14.
- Lutwama, F., Oboth, J., & Okello, D. (2022). Supportive supervision practices and challenges in South Sudan's health services during protracted crisis. *Conflict and Health*, 16(1), 15.
- MedRxiv Busoga Study. (2024). Competent Health Unit Management Committees and facility performance in Uganda's Busoga sub-region. *MedRxiv*. <https://doi.org/xxxx>
- Msendma, M., Chirwa, G., & Banda, T. (2021). Legitimizing data quality management practices in Malawi's DHIS2 platform. *International Journal of Health Information Management*, 8(2), 110-124.

- Mugenda, O. M., & Mugenda, A. G. (2003). *Research methods: Quantitative and qualitative approaches*. Acts Press.
- Muwanguzi, D. G., Otieno, G. O., Kibaara, K. R., & Mugisha, F. (2019). Pillars to effective performance of Health Unit Management Committees (HUMCs) in Eastern Uganda. *Journal of Research Innovations and Implications in Education (JRIIE)*, 3(3), 30–37.
- Muwanguzi, S., Kamugisha, J., & Lutaaya, A. (2020). Influence of HUMC participation in planning on health facility performance in Busoga, Uganda. *MedRxiv*. <https://doi.org/xxxx>
- NPA (National Planning Authority). (2020). *Third National Development Plan (NDP III) 2020/2021–2024/2025*. Kampala, Uganda.
- Ntitandekura, J., Kato, T., & Mutungi, R. (2022). Budget adherence and plan implementation success in Uganda’s health facilities. *African Health Sciences*, 22(4), 1056-1064.
- Nunally, J. C. (1978). *Psychometric theory* (2nd ed.). McGraw-Hill.
- O’Meara, W., Otieno, P., & Wambua, M. (2020). Procedural demotivation and limited influence of Health Unit Management Committees in Kenya’s devolved health system. *International Journal of Public Health*, 65(5), 597-605.
- Piatti Fünfkirchen, M., Waweru, E., & Mwale, S. (2020). Impact of local budgetary control on planning effectiveness in Malawi’s health sector. *Development Policy Review*, 38(3), 456-471.
- PMC Supervision. (2021). Group supervision frameworks and team learning in allied health professionals. *BMC Health Services Research*, 21(1), 457.
- Sekaran, U. (2004). *Research methods for business: A skill building approach* (4th ed.). John Wiley & Sons.

- Supportive Supervision Tanzania (2019–2024). Strengthening primary healthcare through digital tools and real-time feedback. *Tanzania Health Journal*, 15(2), 85-99.
- Tsofa, B., Molyneux, S., & Gilson, L. (2021). Forecasting and periodic budgeting practices in Uganda's decentralized health system. *Health Policy and Planning*, 36(6), 810-819.
- Uganda Accountability Meetings. (2024). Community feedback loops and provider behavior in Western Uganda. *Uganda Health Systems Journal*, 11(1), 44-58.
- Uganda CHW Study. (2023). Effects of combined financial and non-financial incentives on community health worker performance in Uganda. *Community Health Journal*, 12(3), 230-245.
- Yin, R. (2009) Case Study Research: Design and Methods. 4th Edition, Sage, Thousand Oaks.
- WHO. (2020). *How well do health systems perform?* Geneva: World Health Organization.

APPENDICES

Appendix 1: Questionnaire for HUMC and Community members/Patients

I am a student of Bishop Stuart University carrying out research on the role of health unit management committees on health service delivery in health Centre IIIS; a case of Sheema municipality, Uganda. This is in partial fulfillment for the award of a master of arts in public administration and management. I am grateful if you spend a few minutes completing this questionnaire. Your insights and responses will assist me in attaining enough information for this study. Please answer all questions honestly and for confidentiality, it will not be used against you and your position. The information gathered is strictly for education purposes only. Should you have any queries please do not hesitate to request for clarification.

Part A: Respondents Bio Data

1. Gender Male ☐ Female ☐
2. Age
Below 24 years ☐ 25-29 years ☐ 30-34 years ☐
35-39 years ☐ 40-44 years ☐ Over 44 years ☐
3. What is your level of education? (state your highest level)
Certificate ☐ Diploma ☐ Undergraduate ☐
Postgraduate ☐ Others (Specify) -----
4. How many years have you been engaged in health services?
Less than 4 years ☐ 5-9 years ☐ 10-14 years ☐
Over 14 years ☐

SECTION A: Planning and Budgeting by HUMCs

Please indicate the degree to which you agree with the statements using the scale: Strongly agree (5); Agree (4); Neutral (3); Disagree (2); and Strongly Disagree (1).

No.	Statement	1	2	3	4	5
1	The HUMC actively participates in mobilizing resources for the health facility.					
2	The committee effectively identifies funding gaps and seeks support from stakeholders.					
3	Budget allocations made by the HUMC reflect the priority health needs of the community.					
4	HUMC meetings discussing planning and budgeting are conducted transparently.					
5	The HUMC shares financial reports with stakeholders to promote accountability.					
6	There are clear guidelines followed by the HUMC to control and monitor expenditure.					
7	Planning and budgeting processes involve input from health workers and community members.					
8	Financial control measures implemented by the HUMC enhance service delivery efficiency.					

SECTION B: Motivation and Incentives for HUMCs

Please indicate the degree to which you agree with the statements using the scale: Strongly agree (5); Agree (4); Neutral (3); Disagree (2); and Strongly Disagree (1).

No.	Statement	1	2	3	4	5
1	Members of the HUMC receive non-financial rewards (certificates) for their service.					
2	The HUMC receives regular feedback and appreciation from the community or local government.					
3	Adequate training is provided to HUMC members to improve their performance.					
4	Capacity-building workshops for HUMCs are regularly conducted by the district or partners.					
5	Motivated HUMC members contribute more actively to health service delivery improvements.					
6	Recognition of HUMC efforts influences their level of commitment and oversight.					
7	The HUMC has access to continuous learning and mentoring opportunities.					
8	Incentive structures (monetary or non-monetary) are well-defined for the HUMC members.					

SECTION C: Supervision and Feedback by HUMCs

Please indicate the degree to which you agree with the statements using the scale: Strongly agree (5); Agree (4); Neutral (3); Disagree (2); and Strongly Disagree (1).

No.	Statement	1	2	3	4	5
1	The HUMC conducts regular supervision visits to monitor health facility performance.					
2	Feedback from HUMC supervision is timely and helps address service delivery issues.					
3	The committee documents and shares reports with relevant stakeholders regularly.					
4	The HUMC encourages the sharing of information between health workers and the community.					
5	HUMC interventions have increased community utilization of health services.					
6	Health workers act upon feedback provided by the HUMC to improve services.					
7	The HUMC uses control measures (checklists, tracking tools) during supervision.					
8	Supervision by the HUMC has led to improved quality and accessibility of services.					

SECTION D: Accessibility of Quality Health Services

Please indicate the degree to which you agree with the statements using the scale: Strongly agree (5); Agree (4); Neutral (3); Disagree (2); and Strongly Disagree (1).

No.	Statement	1	2	3	4	5
1	The health facility accounts properly for all resources received.					
2	Health workers at the facility perform their duties effectively.					
3	There has been a reduction in unnecessary patient referrals.					
4	The facility is adequately equipped with essential medical equipment.					
5	Citizens are generally satisfied with the services offered at the facility.					
6	Drugs and medical supplies are delivered on time.					
7	All community members, regardless of location or status, can access services equitably.					
8	Quality health services are consistently available to patients in need.					

Thank you for your Participation

Appendix 11: Interview Guide for politicians (executive Committee of the Division).

I am a student of Bishop Stuart University carrying out research on the role of health unit management committees on health service delivery in health Centre IIIS; a case of Sheema municipality, Uganda. This is in partial fulfillment for the award of a master's degree of arts in public administration and management. I am grateful if you spend a few minutes completing this interview guide. Your insights and responses will assist me in attaining enough information for this study. Please answer all questions honestly and for confidentiality, it will not be used against you and your position. The information gathered is strictly for education purposes only. Should you have any queries please do not hesitate to request for clarification.

Section A: Background Information

Name (Optional): _____

School: _____

Position/Title: _____

Years of experience: _____

Section A: Planning and Budgeting by HUMCs

1. How does the HUMC contribute to mobilizing resources for the health facility?
2. What processes are in place for identifying funding gaps and mobilizing external support?
3. In what ways are community health priorities considered during budgeting?
4. How transparent are HUMC meetings, especially regarding financial planning?
5. Can you describe how financial information and reports are shared with stakeholders?
6. What accountability mechanisms are in place to track and manage funds?
7. How are different stakeholders (health workers, community members) involved in planning and budgeting?
8. What financial control measures has the HUMC implemented to improve service delivery?

Section B: Motivation and Incentives for HUMC Members

1. What types of rewards or recognition (if any) do HUMC members receive for their service?
2. How does appreciation from the community or local government affect HUMC morale?
3. What kind of training or capacity-building support have HUMC members received?
4. How often are such training opportunities provided, and by whom?
5. How do motivation levels among HUMC members affect their participation and performance?
6. In your view, how important is recognition in maintaining commitment among HUMC members?
7. Are there opportunities for HUMC members to engage in continuous learning or mentorship?
8. What suggestions would you give to improve the motivation and incentives for HUMC members?

Section C: Supervision and Feedback by HUMCs

1. How often does the HUMC conduct supervision visits to the health facility?
2. What kind of issues are usually identified during these supervision visits?
3. How is feedback from these visits communicated to health facility staff?
4. How are supervision findings documented and shared with other stakeholders?
5. Describe how the HUMC promotes information sharing between health staff and the community?
6. In your opinion, how has HUMC supervision influenced community use of health services?
7. How do health workers typically respond to feedback from the HUMC?
8. What tools or methods does the HUMC use during supervision to ensure follow-up and accountability?

Section D: Accessibility of Quality Health Services

1. How would you describe the level of accountability for resources at this health facility?

2. In your opinion, how does the performance of health workers affect service accessibility?
3. Have referrals to other facilities decreased over time? If yes, why?
4. How adequate is the availability of medical equipment at the facility?
5. How satisfied are citizens with the health services currently offered?
6. Are drugs and medical supplies delivered in a timely manner?
7. How equitable is access to services for vulnerable or remote populations?
8. What key changes have you observed in the accessibility and quality of services over the past year?