### GOOD GOVERNANCE AND PERFORMANCE OF HEALTH CENTERS IN LOCAL GOVERNMENTS OF UGANDA: A CASE OF NDEJJE HEALTH

**CENTRE IV, WAKISO DISTRICT LOCAL GOVERNMENT**

**BY**

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**DEGREE OF MASTER IN PUBLIC ADMINISTRATION OF**

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## DECLARATION

I, **Mbabazi Joanitah Sebamala,** hereby declare that this dissertation entitled” Good governance and Performance of Health centers in Local Governments of Uganda: A case of Ndejje health center IV in Wakiso district local government” is my original work that has not been submitted for award of a degree or certificate at any University or Institution.

Signed; … ………………………………………

Date: ……………………………………………..

#

## APPROVAL

We, the undersigned, certify that the dissertation by Mbabazi Joanitah Sebamala titled *“Good Governance and Performance of Health Centers in Local Governments of Uganda: A case of Ndejje Health Centre iv in Wakiso District Local Government”* has been submitted with our approval in partial fulfillment of the requirements for the award of the degree of Masters in Public Administration of Uganda Management Institute

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## DEDICATION

This work is dedicated to my Dear Husband; Sebamala Richard whose love and encouragement enabled me to push until the end.

## ACKNOWLEDGEMENT

I would like to express my sincere thanks to a number of people whose assistance and contribution made this study possible.

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## LIST OF ACRONYMS

CAO : Chief Administrative Officer

CM : Chairman

HC : Health Centre

HUMCs : Health Unit Management Committees

ISPI : International Society for Performance Improvement

LC : Local Government

MOH : Ministry of Health

RDC : Resident District Commissioner

SPSS : Statistical Package for Social Scientists

Std : Standard Deviation

UGX : Uganda Shillings

UK : United Kingdom

UMI : Uganda Management Institute

US : United States

USA : United States of America

## ABSTRACT

*Introduction:* The study examined the relationship between governance and performance of health centers   in Local Governments of Uganda, taking a case of Ndejje Health centre IV. Specifically, the study examined the relationship between citizen participation; transparency; and accountability on the performance of Ndejje health center IV.

*Methodology:* The study adopted a cross sectional survey research design that employed both qualitative and quantitative approaches. Data was collected using a structured questionnaire, an interview guide and documentary review check list. Whereas quantitative data was analyzed using descriptive and inferential statistics, qualitative data was analyzed using content analysis and thematic methods.

*Findings:* The study established that there was significant positive relationship between citizen participation and the performance of Ndejje health center, that there is a significant positive relationship between transparency and the performance of Ndejje health center and finally that there is a significant positive relationship between accountability and the performance of Ndejje health center.

*Conclusion:* The study concludes that citizen participation as a component of governance is essential for making effective health care a reality. It is necessary for improving the quality health-care service delivery and aligning systems for improvements to occur. Involvement of stakeholders improves planning as health policies are tailored to what really matters for them in health service provision.

*Recommendations:* The study recommends for MOH enhances capacity building among the citizens to be able assess health systems with a governance module for the assessment of governance in the health system into either rules-based or outcome-based indicators or topics essential for key health sector governance.

# CHAPTER ONE

# INTRODUCTION

## Introduction

Governance is apparently heralded as a panacea for organizational growth and cannot be over emphasized for efficiency gains in service delivery especially health systems performance (Savedoff 2011, Brinkerhoff and Bossert 2008 & Stewart, 2013). This study is thus an investigation into the relationship between good governance and performance of health centers in local governments of Uganda using a case of Ndejje health center IV in Wakiso district local government. This chapter presents the background of the study which unpacks four systematically linked perspectives namely; historical, theoretical, conceptual and contextual perspectives. It further gives the statement of the problem, the general objective**,** the specific objectives of the study, research questions, hypothesizes and the conceptual framework. In addition, it highlights the scope of the study, the significance, justification and operational definitions of key terms used in the study.

## 1.2 Background of the Study

## 1.3 Historical Background

The term governance in its metaphorical sense was first attested by [Plato](https://en.wikipedia.org/wiki/Plato) in England's Great Charter of 1215. This was generally recognized as the world's first groundbreaking Constitution that set major limits on the English monarchy and strengthened the concept of power-sharing in decision making (MacNeil, (2014). Furthermore, reforms were added during the years and centuries which followed, culminating in the 1689 Bill of Rights which transferred all effective political power to Parliament. To this end, power moved to the people making participation and involvement quite paramount.

The evolution of governance in English language can be traced to as early as modern England, when the phrase "governance” appeared in the works of [William Tyndale](https://en.wikipedia.org/wiki/William_Tyndale) in 1831 (Bevir, 2013) and in royal correspondence between [James V of Scotland](https://en.wikipedia.org/wiki/James_V_of_Scotland) and [Henry VIII of England](https://en.wikipedia.org/wiki/Henry_VIII_of_England) (Hufty, 2011). The first usage in connection with institutional structures as distinct from individual rule was is in 1885 in the governance of England. The usage of the term governance to refer to the arrangements of governing became conventional in 1904 and among some later British constitutional historians and scholars (Hufty, 2011).

Good governance in its current broader sense rejuvenated in the late 1990s and the early part of the 20th Century. It was re-minted by economists and political scientists, emphatically disseminated by institutions such as the [UN](https://en.wikipedia.org/wiki/United_Nations), [IMF](https://en.wikipedia.org/wiki/International_Monetary_Fund) and [World Bank](https://en.wikipedia.org/wiki/World_Bank) (Heritier, & Silvestri, 2012). It is said to be a transition from Public Administration to New Public Management (Chowdhury & Skarstedt, 2005). According to Eaton and Michael (2016), in 1992, the [World Bank](https://en.wikipedia.org/wiki/World_Bank)  took a concern with the reform of economic and social resource control. It  underlined three aspects of society that they felt affect the nature of a country's governance namely; the  type of political regime,  process by which authority is exercised in the management of the economic and social resources, with a view to development and capacity of governments to formulate policies and have them effectively implemented. In I996, the [International Monetary Fund](https://en.wikipedia.org/wiki/International_Monetary_Fund) (IMF) emphasized “promoting good governance in all aspects of procedures, including ensuring the rule of law, improving the efficiency, accountability of the public sector and tackling corruption as essential elements of a framework within which economies can prosper (Eaton & Michael, 2006).  To this end, to receive loans from the IMF, countries had to possess certain good governance policies, as determined by the IMF in place (IMF' 2005, Eaton & Michael, 2006).

Castro (2013) reports that since the early years of the 2000s, tenets of good governance were put in place. In the United States, the [Sarbanes–Oxley Act](https://en.wikipedia.org/wiki/Sarbanes%E2%80%93Oxley_Act) of 2002 set up requirements for businesses to follow (Eaton & Michael, 2007). The International Budget Partnership (IBP) launched the [Open Budget Initiative](http://internationalbudget.org/what-we-do/major-ibp-initiatives/open-budget-initiative/) in 2006 with the release of the first [Open Budget Survey (OBS)](http://internationalbudget.org/what-we-do/open-budget-survey/). Major donors and international financial institutions, like the [International Monetary Fund](https://en.wikipedia.org/wiki/International_Monetary_Fund) (IMF) or World Bank, started basing their [aid](https://en.wikipedia.org/wiki/Foreign_aid) and loans on the condition that the recipient undertake reforms ensuring good governance ([UNESCAP](https://en.wikipedia.org/wiki/UNESCAP), 2009). A Worldwide Governance Index (WGI) ([World Governance Index Report, 2009)](http://www.world-governance.org/spip.php?article469)  was developed in 2009 to ensure good governance.  Additionally, in 2009 the Bertelsmann Foundation published the [Sustainable Governance Indicators](https://en.wikipedia.org/wiki/Sustainable_Governance_Indicators) (SGI), which systematically measures the need for reform and the capacity for reform within the [Organization for Economic Co-operation and Development](https://en.wikipedia.org/wiki/Organisation_for_Economic_Co-operation_and_Development) (OECD) countries (Empter & Janning, 2009).

On the African continent, good governance became pronounced in the early 1990 as a condition of international development partners to extend assistance (ADR, 2010 & Muyambi, 2013). In Uganda, good governance is enshrined in the decentralization policy which was adopted by Uganda government in a Presidential pronouncement   in October, 1992.  This led to the enactment of the Decentralization Statute of 1993. Since then, it has become the International hallmark of the country’s political transformation and service delivery. All aspects of government administration and policy action were affected by the devolution of functions, competency and resources to the lower levels of service delivery (Kamba 2008).  It hinged on a participatory decision making process mainly through identification of local problems, priorities and solutions by communities (Local Government Act, 1997).

Good governance is vested in the Constitution of the Republic of Uganda 1995 and the Local Governments (LG) Act 1997 which transferred political, administrative and fiscal powers from central government to local councils. It made Local Governments responsible for the delivery of the bulk of services and accountable to their constituents. This policy framework promoted popular participation by empowering local people to make decisions about their own development priorities. In addition, the Constitution of the Republic of Uganda 1995 and the LGs Act of 1997 devolved service delivery mandates to LGs while line ministries retained the mandate for setting national policies and standards regarding the delivery of those services.   To facilitate, LGs to fulfill this mandate, a number of local financing powers were also devolved to LGs. LGs were allowed to levy, charge, collect and appropriate  fees and taxes from rents, rates, royalties, stamp duties, personal graduated tax,  market dues, and fees on registration and licensing for financing  local district government  priority areas. LGs were also given autonomy to plan and budget through a participatory bottom-up process where priorities of lower LGs were to be incorporated in the higher LG plans (Malenga, 2017).

### 1.3.1 Theoretical Background

This study was guided by the Stakeholder Theory of Freeman (1984). Without their engagement, knowledge, skills, talent, loyalty, the organization could not achieve its objectives. In general the concept is about what the organization should be and how it should be conceptualized. Although the practice of stakeholder management is long-established, its academic review started only at the end of 70s. In a seminal paper, Freeman (1978) presented two basic concepts, which underpin stakeholder management. The first is that the central goal of the stakeholder management is to achieve maximum overall cooperation between all stakeholder groups and the objectives of the corporation. The second says that the most efficient stakeholder management policy involves efforts, which simultaneously deal with issues affecting multiple stakeholders. Stakeholder management tries to combine groups with a stake in the firm into managerial decision-making. Stakeholder management facilitates consideration of individuals or groups within and outside the firm when allocating organizational resources. Stakeholder management promotes an effective allocation of resources among stakeholders to achieve a “win-win” outcome.

Friedman (2006) states that the organization itself should be thought of as grouping of stakeholders and the purpose of the organization should be to manage their interests, needs and viewpoints. This public participation is thought to be fulfilled by the managers of firm. The managers should on the one hand manage the corporation for the benefit of its stakeholders in order to ensure their rights to participation in decision making.

Stakeholders may bring an action against the directors for failure to perform the required duty of care (Freeman 2004). In some literature the own interest is conceived as the interests of the organization, which is usually to maximize profit or to maximize shareholder value. This means if managers treat stakeholders in line with the stakeholder concept the organization will be more successful in the long run.

The stakeholder is any individual or group that may affect the achievement of the organization goals or that is affected by the process of searching for the organization objectives (Gilley, 2005). Freeman (1984) states that stakeholders are groups that have a legitimate right regarding the organization. To this end, stakeholder theory emphasizes the participation and involvement of the people who are affected by the undertakings of the organization or the user system.

 In relations to this study, the theory, empowers and guides the citizens through local councils and HUMCs to participate in the health provision. This is a component of good governance.   Good governance tries to promote more relationships between government and [citizens](https://en.wikipedia.org/wiki/Empowerment) through   local councils. It thus increases civil engagement with more members of the community in order to get the best options that serves the people (Rocha, 2011).  To this note, good governance takes into account the interests of the public good and the people as stakeholders.

Jensen (2010) postulates that the firm will have superior performance if the stakeholders are brought on board of management.  Jones (2005) for example suggests that organizations with relationships supported by trust with their stakeholders develop a competitive advantage over other companies. The stakeholder theory indicates that the objective of the organization is to coordinate the interests of the stakeholders. This facilitates transparency, accountability and value for money.

In relation to this study and in the context of a local governments, good governance is related to aspects like providing public services in an efficient manner, giving higher participation to certain groups in the population like the poor and the minorities, ensuring citizens have the opportunity of checks and balances on the government, establishing and enforcing the norms for the protection of the citizens and their property and the existence of independent judiciary systems (Grindle, 2004). According to Grindle (2004) the relevance of getting good governance comes from its relationship with the stakeholders.

### 1.3.2 Conceptual Background

The key concepts in this study are governance and performance of local government health centers. Governance derives from the Greek verb kubernáo literally meaning to steer. World Bank (2007) defines good governance as a situation when the public sector operates according to the principles of transparency, accountability, predictability, responsiveness and participation. In addition, Welch and Nuru (2006) postulates that governance refers to the ways in which stakeholders interact with each other in order to influence the outcomes of public policies. Kaufmann et al (2007) and Kaufmann and Aart (2008) define governance as the traditions and institutions by which authority in a country is exercised for the common good, which includes the process of selecting those in authority, capacity of the government to manage and respect for the state.

According to IFAC (2013), the principles of good governance include; a strong commitment to integrity, ethical values, the rule of law, openness and comprehensive stakeholder engagement. This should be consequential to defining outcomes in terms of sustainable economic, social, environmental benefits and determining the interventions necessary to optimize the achievement of intended outcomes. In addition, the principles include developing the capacity of the entity, including the capability of its leadership and the individuals within it; managing risks and performance through robust internal control. Yet more, it should espouse strong public financial management and implementing good practices in transparency and reporting to deliver effective accountability. It is from these principles that dimensions for the study were derived.

On the other hand, performance of local government health centers refers to the extent to which resources allocated to health are utilized to achieve the intended healthcare outcomes. Performance of health centres refers to such things as staff output, drug and medical supply availability, regularity of funding transfers, state of physical infrastructure, inventory and functionality of equipment and existence of patient records. It further refers to factors which reflect whether health systems are meeting minimal efficiency and quality standards to attain patient satisfaction (Lewis 2006). In addition, according to Savedoff (2011) performance of health centers refers to regular attendance of staff, governance arrangements that promote managerial actions to recruit, motivate, supervise and discipline staff to comply with their formal work obligations. Kamba (2008) describes Health centers as ranging from health center IV serving a county, HC III serving a sub county and HC11 serves a parish. Performance of local government health centers refers to how the user system derives satisfaction and how services are delivered to them.

### 1.3.3 Contextual Background

Every District has health centre one, two three and four. There are three HC IVs which include, Kasangati, Namayumba and Ndejje in Wakiso. However, a number of these centers are faced with challenges ranging from inadequate staff to dilapidated structures. In spite of empowerment and decentralized planning enshrined in good governance, ACODE , 2013, 2014 MoLG (2011), MoLG (2012) and Wakiso DDP 2011-2015 shows that social services have various problems and gaps and are not meeting national requirements. The health worker staffing levels in the district health units is still inadequate at 78% while some lower health units lack stand by staff (ACODE 2014). Essential drug stock outs are still eminent in health units (Wakiso District Score Card 2012) while the general cleanliness at health units remain wanting (SPA, 2008). Ndejje health centre is at level IV in the decentralized health care structure in Uganda serving a population of about 200,000 people. It is a peri-urban health centre located in the outskirts of

 However the systems, put in place have not effectively helped to improve the performance of the health sector. For example the problems that bedeviled the health sector during the first year of Ndejje Health centre assessment still linger on. The problem of health staffing is most pronounced at Health Centre IIs. For example, residents reiterated the problem of the Health Centre which was rarely open and also experienced frequent drug stock outs. There is a significant decline in health service deliveries by over 15%. Indeed, there is evidence to believe that the suboptimal performance for TB service delivery targets is attributed to the decline in the performance of health systems. There have been many cases where patients have been referred to bigger hospitals but with no ambulance (Kigonya, 2017).

There is poor sanitation, bushy compound with staff irregularity (ACODE 2012 & 2013). It is therefore not clear how good governance has influenced performance of the health sector in local government health centers which formed the basis of this study.

## 1.4 Statement of the Problem

In spite of the good governance practices, the performance of Ndejje health center IV is still below expectations. There is a significant decline in health service deliveries by over 15% IN Sub Saharan Africa (WHO, 2017). Indeed, there is evidence to believe that the suboptimal performance for service delivery targets is attributed to the decline in the performance of health systems (WHO, 2017). In Wakiso District, health workers are used to absenting themselves, they delay in attending to patients and do use abusive language including neglect of patients (Wakiso Community Development Officer Report, 2017). There have been many cases where patients have been referred to bigger hospitals but with no ambulance (Kigonya, 2017). In addition, Kigonya (2017) who carried out a study on health service delivery in Wakiso found out that health facility lacked sanitation facilities, had a bushy compound with patient’s long queues. There is rampant drug stock-outs, absenteeism of health workers, delays, less care for patients and patients express dissatisfaction with health services delivered (Muganga 2016). This scenario forms a gap as regards good governance and performance of the health center.  If this situation is not attended to, good governance efforts will not attain efficiency gains consequently leading to high morbidity and mortality compromising the quality of the population and national development. It is against this backdrop that the researcher sought to examine the relationship between good governance and performance of health centers in Uganda, taking a case of Ndejje Health centre IV, Wakiso district local government.

## 1.5 General Objective of the Study

The general objective of the study was to investigate the relationship between good governance and performance of health centers   in Uganda, taking a case of Ndejje Health centre IV, Wakiso district local government.

## 1.6 Specific Objectives of the Study

The study was guided by the following objectives;

1. To examine the relationship between citizen participation and the performance of Ndejje health center

2. To examine the relationship between transparency and the performance of Ndejje health center

3. To examine the relationship between accountability and the performance of Ndejje health center

## 1.7 Research Questions

The study attempted to seek answers to the following research questions;

1.  Whether there is a relationship between citizen participation and the performance of Ndejje health center?

2. Whether there is a relationship between transparency and the performance of Ndejje health center?

3. What is the relationship between accountability and the performance of Ndejje health center?

*1.8* ***Research Hypothesizes***

1.   There is a significant positive relationship between citizen participation and the performance of health centres in Uganda

2. There is a significant positive relationship between transparency and the performance of health centres in Uganda

3. There is a significant positive relationship between accountability   and the performance of health centres in Uganda

1.9 Conceptual Framework Showing **the Relationship between Good Governance and Performance of Local Government Health Centers**

**Independent Variable (IV)                                               Dependent Variable (DV)**

**Good Governance Performance of Health Centers**

**Citizen Participation**

* Citizen involvement in health planning
* Citizen monitoring

Health Worker Performance

Staffing strengths

Health worker availability

Health workers attitudes

Health worker commitment

Health Budget Performance

 Funds reaching facility

Stock of essential drugs

Cleanliness

Facility Outputs

Health utilization

Client satisfaction

|  |
| --- |
|  |

**Transparency**

* Accessibility to health information
* Reporting

**Accountability**

* Public Expenditure Tracking
* Enforcing rules and regulation

**Source:**  *Adopted and refined from World Bank (2007), Kaufmann and Aart (2008) and Savedoff (2011)*

Figure 1. 1:The Relationship between Good Governance and Performance of District Local Governance Health Centers.

The conceptual framework describes the relationship between the independent and the dependent variables. In this conceptual framework, good governance is conceived as the independent variable while performance of district local government health Centre’ is the dependent variable. It is therefore assumed that the ideal performance of local government health centers depends on good governance exhibited.

Good governance is operationalized into citizen participation, transparency and accountability. On the other hand, performance of district local government health centers has indicators such as availability of essential drugs in health centers ,  accessibility of patients to  health centers,  health worker presence in public health  centers,  proportion of government funds reaching health centers, absence of  informal payments within  health centers, positive health worker attitudes to patients and  client satisfaction.

Arrows have been used to show the direction of the relationship. The conceptual framework was adopted from World Bank (2007) and Kaufmann and Aart (2008) elaborate on the principles of good governance which were used to form the objectives of the study. On the other hand, Savedoff (2011) substantiates on performance of health centers in local governments which were used to come up with the indicator of the study. It is therefore perceived that citizen participation, transparency and accountability which are strong principles of good governance when exhibited earnestly in local government health centers have to ensure that health resources are invested as disbursed which is consequential to improved health service performance to elicit desired health outcomes.

**1.10 Significance of the Study**

The study will be of value to the following categories of people thus:

The study findings will inform policy and decision makers to influence performance of the health centers in local governments through good governance principles. This can be achieved by institutionalizing good governance schemes and standards in normal routines.

The study will be useful to local government leaders to institute   better mechanisms and schemes to attain performance for effective health service delivery. This can be achieved by instituting local and relevant good governance parameters at the department level to activate good governance morale towards service delivery.

Findings will better inform community as stakeholders to influence health sector performance through participation to influence transparency and accountability. This they can attain through monitoring and supervision

The study results might stimulate impetus for replication in other related subject content areas and geographical areas. It might also provide data for further analyses. This can be achieved through using the collected data.

The findings will provide literature to the world of academia on good governance and service delivery.

## 1.11 Justification of the Study

The concept of good governance is rather enigma since it focuses on deepening democratic engagement through the participation of citizens in the processes of providing the public good (Bevir, 2013). The idea is that citizens should play more direct roles in public decision-making or at least engage more deeply with political issues. Similarly, government officials and service providers should also be responsive to citizen engagement. This spurs the roles of citizens as users system, voters or as watchdogs through more direct forms of involvement by holding the government accountable (Hufty, 2011).

However, despite the strong emphasis on improving services to the people, the tenets and benefits of good governance still remain far from realizing benefits. The principles are varied and keep shifting Agere (2010). The discretionary space left by the lack of a clear well-defined scope for what governance encompasses allows implementers to choose and set their own parameters. Poluhaand & Rosendahl (2009) contest standards that are common to western democracy as measures of good governance. Applying [political anthropological](https://en.wikipedia.org/wiki/Political_anthropology) methods, they conclude that while governments believe they apply concepts of good governance while making decisions, cultural differences can cause conflict with the heterogeneous standards of the international community (Poluha & Rosendahl, 2009). In addition, Munshi (2013) ascertain that many individuals, institutions and governments tend to either wave away and be bored with the idea of good governance, or not have a clue to what it has at all.  Similarly, Crozier (2013) analyzing good governance finds different dynamics of changes that occur throughout implementation that affect performance and application.

The various perspectives may not be an exception to Waksio district local government and more so in particular Ndejje health centre which may compound contemporary good governance through different pairs of eyes and application. The way governance and policy within Waksio district local government health centers and civil, society operate, especially with the constant changes occurring day to day has not been ascertained. This requires thorough investigation to inform local government decisions to harmonize the efficiency gains of good governance trough policy and practice.

## 1.12 Scope of the Study

The scope was considered under geographical, content and time aspects. This was intended to give boundaries to the study in the respective aspects.

### 1.12.1 Geographical Scope

The study was conducted in Wakiso district local government specifically in Ndejje health IV.  It is a peri-urban health center located in the outskirts of Uganda’s capital, Kampala. The health center is found in Zanta zone.

### 1.12.2. Content Scope

The study investigated the relationship between good governance and performance of the health centers in Wakiso district local government. More specifically, good governance was ascertained by citizen participation, transparency and accountability. Performance of the local health centers on the other hand, was measured in terms of patient satisfaction, availability of drugs, availability of staff proportion of government funds reaching Ndejje health center.

### 1.12.3 Time Scope

The study concentrated on the period 2014-2016. The period of three   years were chosen because it could offer a trend for analysis of the problem of investigation

*1.13 Operational Definition of key Terms*

Good governance: refers to how local government leaders and service providers in the district health centers exercise citizen participation, account to the stakeholders and make information regarding health service provision accessible in a transparent manner.

Citizen participation: refers to how district local council leaders, CSOs in the district and HUMCS are allowed space in health planning and monitoring.

Citizen involvement in health planning: refers to how local people through their representatives are allowed in health decision making and budgeting and how this in incorporated in local district plans.

Citizen monitoring: refers to how community people visit local health center’s to ensure that plans and decision are implemented in regard to common good to minimize leakage.

Transparency refers: refers to the way stakeholder’s access informing regarding health service provision and how budgets have been utilized. In addition it refers to the way how health providers make reports in an open manner accessible to all interested stakeholders

Accountability: refers to how local government leaders and health service providers enforce rules and regulations regarding health service provision yet accompanied with regular health public expenditure trucking

Enforcing rules and regulations. The way local government leaders and service providers follow budget specifications

Public Expenditure Tracking. Refers to the follow up by stewards to ensure that the local government leaders and service providers have put the health budgets into the use.

Performance of district local government health centers: refers to how local government leaders and service providers attain health objectives as laid in the national and local government health provision guide lines.

Availability of essential drugs in health centers:   This refers to the six basic drugs that should be available at the health centers all the time for essential treatment of patients.

Accessibility of health centers:   refers to the willingness of patients to visit health centers and find service providers to attend to them and not finding health centers closed.

Health worker presence in public health centers. Refers to how health workers are always available to attend to patients as designed by the level of the health center

Proportion of government funds reaching district-level facilities: refers to whether the amount budgeted for the health center actually reach and is invested as per the budget

Proportion of informal payments within the public health care system: refers to whether patients are made to pay some money yet health centers are supposed to be free.

Client/patient satisfaction: refers how patients perceive the services they receive at the health centers.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

This chapter reviews the literature related to good governance and performance of health centers in district local governments. The chapter has two sections. The first section presents the theoretical review while the second section presents the related review of related literature in line with study objectives and corresponding dimensions.

## 2.2 Theoretical Review

The study was underpinned by the Stakeholder Theory. The study will be guided by the stakeholder’s theory that was propounded by Freeman in 1984. In general the concept is about what the organization should be and how it should be conceptualized. Friedman (2006) stated that the organization itself should be thought of as grouping of stakeholders and the purpose of the organization should be to manage their interests, needs and viewpoints. This stakeholder management is thought to be fulfilled by the managers of firm. The managers should on the one hand manage the corporation for the benefit of its stakeholders in order to ensure their rights to participation in decision making.

Stakeholders may bring an action against the directors for failure to perform the required duty of care (Freeman, 2004). In some literature the own interest is conceived as the interests of the organization, which is usually to maximize profit or to maximize shareholder value. This means if managers treat stakeholders in line with the stakeholder concept the organization will be more successful in the long run.

Stakeholder participation is considered to be a critical factor governing the delivery of health care services. Public health care services are accountable to citizens indirectly through the mechanisms by which political authorities are elected or appointed (World Bank 2014). Creating channels for stakeholder participation in managing or supervising public health care services improve health systems performance. Giving citizens a role in supervising public health care services or soliciting their feedback on service quality provide useful information which pressure to improve public health care service quality and productivity (Lewis, 2006). Opening policy decisions, community can safeguard the medical quality of care and protect health user interests (Savedoff 2011). A variety of health sector policy documents have advocated for greater stakeholder participation as a worthwhile element of health sector governance. In such cases, greater stakeholder participation would be considered to be a better governance instrument regardless of the impact on health care service performance (Savedoff, 2011).

However, studies argue that greater stakeholder participation can harm public health care service provision. Opening public agencies to stakeholder participation can distort decisions in favor of particular groups. Citizen Representatives can influence decisions to their own benefit in ways that may be detrimental to others in the community. There is a problem of elite capture (Gauthier, 2006). A survey conducted in 2005 and 2006 ( cited in Kamba 2008) as part of medium-term review of LGDP II in a sample of local government jurisdictions revealed that respondents knew very little about the procedures for holding leaders accountable especially in decentralized setting. People have diverging views and more other pressing needs than to go for meetings to plan and use the power entrusted to them to hold service providers accountable and inclusion of what they perceive as vital in health service delivery. In addition, stakeholder participation goes with knowledge and skills which in most cases local communities lack.

## 2.3 Related Literature Review

### 2.3.1 Citizen Participation and Performance of Health Centers

Citizen participation is a critical component of good governance (Tritter et al, 2010). Participation means that affected parties have access to decision-making and power so that they acquire a meaningful stake in the work of the institution (Tritter and McCallum 2006; Banyan 2007; Weale 2007; Urbinati and Warren 2008; Tritter et al. 2010; Stewart 2013). Joint decision making create opportunities for information sharing, defining mutual objectives and critical assessment, of service quality, effectiveness and efficiency monitoring and evaluation for quality improvement. In bridging the gap, this promotes to monitor service delivery, encourage service providers to measure and improve their performance.

Participation is a distinctive form of involvement. It is both empowering and proactive as it enables the less powerful members of society to exercise power over matters that concern them. Participation takes different forms; it may be social or political in nature (Adams, 2008) Participation in relation to society can be described as a process in which the act of making decisions is divided equally among the ones they affect. Participation, according to Hart (1992) is an essential part of democracy implying that not only power holders can influence the decision-making process, but also the citizens. This section therefore looks at citizen participation from citizen involvement in health planning and monitoring of health programs to ensure that the decisions or plans are effectively implemented.

#### 2.3.1.1 Citizen Involvement and Performance of Health Centers

Seekings (2013) and Bevir (2013) found that system user involvement in planning such as participatory budgeting resulted in greater health improvements. Similarly, Fung (2006) found that effectively structured participation in planning improves legitimacy and ownership of the service institution. Dominguez (2011) reports that consulting affected parties can produce very useful information about, for example, the functioning of little-understood public services that a government is thinking about reforming, or about practical difficulties that might arise from a proposed policy. The findings however lack empirical analyses and relied on literate basis. They may therefore not be useful to draw conclusions for performance of local government health centers and Ndejje in particular making this study imperative.

DFID (2011) found that in Malawi women are the primary users of most health services provided at local level, but have low social statuses, limited voice and mobility, with low levels of literacy, which constrains their capability to engage with service providers in planning. Similarly, Cammack’s study (2012) of governance and service delivery highlighted several ways in which the political context affected the effective citizen involvement in the planning for the provision of public goods in the peri-urban context of Malawi. The findings revealed incoherent policy making, non-compliance with rules and regulations and the creation of networks reaching from national to grassroots levels to control public resources which limited citizen involvement in decision making and planning. The findings however stop at elucidating the limitations of involvement of citizens in decisions of service provision without exploring how this affects performance of health centers which may not be useful to inform policy and practice at Ndejje health center thus warranting the necessity of this study to adduce evidence for the performance local government health centers.

Gaventa and Barrett (2010) in a study evaluating 100 case studies that mapped the outcomes of citizen engagement, find over 30 cases in which significant impacts were made in service delivery including in the health and education sectors. For example, in Brazil, the new participatory governance councils have been significant in improving access and quality of health care services. In Bangladesh, parents of girls in schools mobilized to monitor teacher attendance and discourage absenteeism. While the methodology used does not emphasize local government health centers and spans out health to education, it is important to synthesize whether the findings can be comparative in the ways similar to district local government health centers and more so Ndejje health center

Misra (2007) found that community involvement in planning for health services in Andhra Pradesh, was consequential to health Services improvement through community social accountability. Similarly, while Ergo et al, (2010) found that planning at the decentralized level remains challenging for both DHOs and DCs, the planning processes for central hospitals are insufficiently linked to the planning processes of the districts they serve. In addition, Mansuri and Rao (2013) in a review of a large number of projects that have sought to apply participatory approaches, found that involving communities in at least some aspects of project design and implementation creates a closer connection between developments. Participation has therefore been seen as an instrument for building ownership and ensuring programme effectiveness. Community participation in the process of public service planning and delivery may also have the potential to improve service effectiveness and responsiveness.

In bridging the gap, while the methodology used does not emphasize local government health centers and spans out health to education, it is important to synthesize whether the findings can be comparative in the ways similar to district local government health centers and more so Ndejje health center

#### 2.3.1.2 Citizen Monitoring and Performance of the Health Centers

Savedoff (2008) in a decentralized setting in Uganda found that Local Health Directorates included local government officials and citizen representatives established to oversee most health care facilities showed that price data collected for various supplies found that hospitals that were supervised by active directorates paid less on average than hospitals that had directorates with less active citizen participation. For instance, hospitals that were supervised by active directorates paid 40 percent less on average for 5 percent dextrose solution. In this case, local supervision combined with citizen vigilance was instrumental to better health performance. This study was rather general for the whole of Uganda and quite a decade earlier. Whether it still holds and more so for district local governments health centers deserves extensive investigation which forms the onus of this study.

Nguyen and Lassibille (2008) report on a random experiment in which different approaches were compared in schools in Madagascar. The findings showed that community monitoring interventions led to significantly improved teacher behaviour, improved school attendance and test scores compared to the top-down interventions which seemed to have minimal effects. Similarly, Olken (2007) in another random experiment in Kenya found that hiring contract teachers along with community monitoring had significant impacts on student achievements. In contrast, Nair (2013) in a widely cited study on citizen monitoring of road projects in Indonesia found that citizen monitoring had little average impact compared to increasing government audits. The difference in the findings could be attributed to difference in geographical context’s and service areas where road monitoring in more technical. However, these findings were arrived at quite earlier and in a different service sector all together definitely, using difference approaches. Thus it is important after a decade to be replicated on the performance of local health centers in district local government and Ndejje health centre so as to draw solid conclusions.

Ravindra (2004) in a review of the citizen report cards in Bangalore by a citizen group called the Public Affairs Centre shows that they have had considerable impact on improving public services. A UN report (2007) later indicated that not only did public satisfaction with services improve, but the incidence of corruption appears to have declined. In addition, Anuradha (2010) report that citizen groups as well as public organizations in Hyderabad, Metro water started a complaint hotline which offered a formal accountability mechanism for citizens. By using this direct link with citizens, managers were able to hold frontline providers accountable. The findings of this evaluation suggested that the performance of frontline workers improved and corruption was considerably reduced.

Dufflo (2013) in a study in Mumbai, India, a citizen group initiated the online Complaint Management System (OCMS) which streamlined all complaints on urban public services into an online database which could be used to compile data on time taken to address complaints compared to set norms. An early World Bank study found that the system was successful in putting pressure on public officials to deal with complaints on time. In another initiative, Sirker and Cosic (2007) found that in Lok Satta, a citizen group in Andhra Pradesh, worked with municipal authorities to publicise citizen charters for forty common public services in one hundred municipalities in the state combined with efficient complaint mechanisms. The charters were combined with the training of citizens to monitor services and a compensation clause that pays citizens Rs. 50 per day of delay in public services. A review of this experience suggests that the charters have worked better in urban areas than in rural areas because of greater awareness. This section therefore looks at citizen monitoring from citizen monitoring in health planning and monitoring of health programs to ensure that the decisions or plans are effectively implemented.

A more mixed assessment of provider based report cards is provided by McNamara (2006) who has assessed their use in the health sector in the United States. She finds that the impacts depend to a large extent on the indicators that are actually used in evaluating providers. In some cases, providers have improved services in response; in others, providers have worked towards improving rankings by using strategies that might undermine services. In the developing world, Uganda has used report cards to rank hospitals (Uganda DISH, 2004). Although no systematic studies of their impact on services have been done, it appears that the average score of providers climbed substantially in the two report card periods (Bold et al 2010). More recent efforts to use Citizen Report Cards are moving away from satisfaction surveys to more objective indicators of the actual quality of services received as is evidenced by the Delivering Services Indicators proposed for education and health services in Africa. In bridging the gap, providers have improved services in response; in others, providers have worked towards improving rankings by using strategies that might undermine services

Analysis of the use of community monitoring by score cards in primary health care services in Andhra Pradesh, India found that there were stark discrepancies between the self-evaluation of providers and the evaluation of communities (Misra 2007). Overall, the process resulted in increased user satisfaction levels and better understanding of the constraints providers face. In Madagascar, assessing services using the Local Governance Barometer (LGB) a process that involved local officials and communities found that there were very low levels of perception of accountability by citizens (Dufils, 2010). The resultant action plan had several positive impacts such as effective channels of collaboration and communication was developed and complaint processes were improved.

Sundet (2004) study on Hakikazi, an initiative in Tanzania is using a hybrid of community score cards and citizen report cards to assess the progress of their Poverty Reduction Strategy. However, the initiative at the time of the study was quite new and too early for evaluating impact. In Uganda, community monitoring by the Uganda Debt Network has been successful in improving facilities at the local level. Monitoring by trained community workers led to the identification of ‘shoddy work’ by contractors in the construction of classrooms and health posts (Renzio et al. 2006). In bridging the existing gap, several cases community monitoring reported some of the equipment allocated to a health post as missing and official investigation led to recovery of the missing material.

Community monitoring can improve the quality of services. In an experiment Bjorkman and Svensson (2009) found that when local NGOs encouraged communities to engage with local health services, they were more likely to monitor providers. As a result, provider absenteeism declined and responsiveness increased in terms of shorter waiting times, greater efforts to respond to community needs. Usage of public health services also increased and was reflected in better health outcomes such as reduced child mortality. These findings reflect a vicious cycle in some public services say poor quality, lack of uptake and interest, resulting in further worsening of quality and lack of accountability.

### 2.3.2 Transparency and Performance of Health Centers

Transparency means that institutions inform the public and other actors of both upcoming decisions and decisions that have been made and of the process by and grounds on which decisions are being made (de Fine Licht 2014).The common theme of transparency mechanisms is that they make it possible to understand an institution, identify possible malfeasance or incompetence and adapt plans to its behaviour. In principle, it can also be an anti-corruption measure, (Vian et al. 2010). The transparency is achieved through accessibility of policy documents related to health laws and bylaws, decisions, information campaigns and reports on analysis (Gahir, 2015). Transparency is built on the free flow of information processes, institutions and information are directly accessible to those concerned with them and enough information is provided to understand and monitor them. This objective has been assessed on accessibility to health information and reporting. In bridging the gap, institutions inform the public and other actors of both upcoming decisions and decisions that have been made

### 2.3.3 Accountability and Performance of Health centres

Accountability involves explanation and sanction (Weale 2011). Bovens (2010) describes accountability as “a pro-active process by which public officials inform about and justify their plans of action, their behavior and results, and are sanctioned accordingly. Accountability requires that public servants have clear responsibilities and are held answerable in exercising those responsibilities, and if they do not, face predetermined sanctions. Without sanctions there cannot be any real accountability. This section has addressed accountability on enforcing rules and expenditure trucking.

Reinikka & Svensson (2006) revealed Surveys from PETS in Africa that it minimize leakage and lead appropriate use of funds. Pande (2008) reports that India pioneered the strategy of using public hearings (Jan Sunvais) to hold public officials accountable for local level implementation of programmes. Jan Sunvais operate by first gathering information about the budgets and expenditure in public programmes and presenting and verifying these in a public gathering in which all relevant stakeholders, public officials, elected leaders, private contractors and workers are present. These early public hearings had significant impact in exposing corruption in public works programmes, and in some instances even getting public officials to return the money that they had appropriated.

Duggal (2005) reports that in Parivartan, a grassroots organization in Delhi held public hearings on the implementation of the Public Distribution System (PDS) which is a large food subsidy programme intended for the poor. The depth of corruption exposed through the process led to improvements in the operation of PDS as well as institutionalization of a system of monthly ‘opening of the books’ for public scrutiny Public hearings have also been held by the Right to Health movement in India in an attempt to expose the poor access to healthcare for the poor and provide an evidence base for advocating reforms. There has been no clear study of their impact.

A study by Singh and Vutukuru (2010) of social audits in the state of Andhra Pradesh where the state has taken a lead in institutionalizing them, found that social audits have led to a statistically significant increase in employment generated, as well as an increase in the exposure of corruption within the programme with a significant amount of programme funds being recovered.

Lindelow (2006) reports that more than two dozen PETS have been conducted in a range of low- and middle-income countries and the experiences demonstrate that the instrument is useful but difficult to compare across countries, particularly in the health sector PETS tend to be most useful where they have been repeated in the same country and can be used to monitor the effects of policy initiatives over time (Dehn 2003). For those interested in conducting a PETS, the 2004 PETS/QSDS instrument used in Chad (that was largely based on the Mozambique 2002 PETS/QSDS) is a good has improved performance.

## 2.4 Summary of Literature Review

The literature reviewed indicates that good governance is a panacea to health service delivery. It enhances community participation, transparency and accountability enforced by the community which propels to put into good use the health resources resulting into promising health outputs**.** However, much of the literature reviewed and discussed was arrived at quite some time earlier, in different geographical contexts and other service areas. The study therefore needs to be replicated in the health sector and more at Ndejje health centre so as to draw concrete conclusions and recommendations**.** Apart from methodological concerns, it appears that the large majority of the studies have focused on hospitals in general rather than local government health centers context, with only a handful of papers based local health systems. Without denying the importance of lessons drawn from the same health systems, there seems to be a clear need to expand research to local governments. In this way, it is instrumental to analyse the impact of good governance models at local government health centres and Ndejje in particular.

# CHAPTER THREE

# METHODOLOGY

## 3.1 Introduction

In this chapter, the methods that were used to conduct this research are described. It discusses the research design, the study population, sample size and selection. It also gives the sampling techniques and procedure, data collection methods and instruments, validity and reliability of instruments. It further elaborates the procedure of data collection and data analysis.

## 3.2 Research Design

This study adopted a cross sectional research design employing both qualitative and quantitative approaches. The cross sectional research design enabled data collected from a population, or a representative subset, at one specific point in time that was [cross-sectional](https://en.wikipedia.org/wiki/Cross-sectional_data) to the problem. It was therefore found suitable for this study that used the triangulation method from the cross section of the population which gives the researcher deeper analysis. Qualitative methods were suitable for the collection of verbal data, facial expressions which contributes to reliability of data. However, collection of numerical data required quantitative methods in form of numbers (Amin (2005). The two methods were deemed substantial to complement each other (Mugenda & Mugenda, 2010)

## 3.3 Study Population

The study population was derived from Ndejje health center IV and included 2 District health officials and 3 officials who included the town Clerk, RDC and C/M. It further included 74 staff members and 91 leaders. The total study population was 168 subjects from which the study sample was selected. This population category was chosen due to its involvement in health service delivery and has vital information as regards good governance in health centers in the local government setting. They therefore had a critical contribution to make to this study.

## 3.4 Sample Size and Selection

The sample size was 138 determined by the use of the Taro Yamane's formula (Miaoulis and Michener, 1976). The acceptable sampling error was usually 0.01 to 0.05 and a sampling error of 0.05 was adopted with confidence level of 95%.

Taro Yamane’s formula;

n=N/[1+N(e)^2]
where:
n= sample size.

N= population size (the universe)

e = sampling error

^ = raised to the power of Yamane statistical formula; and the confidence level was 95%

Therefore the sample size for the study was;

n=168/[1+210(0.05) ^2]

n=138

Table 3. 1: Table Showing the Study Population and Sample Size

|  |  |  |  |
| --- | --- | --- | --- |
| Category |  Population(N) | Sample size | Sampling technique |
| Health officials  | 03 | 03 | Purposive |
| Health workers  | 74 | 60 | Simple random |
| Leaders  | 91 | 75 | Simple random sampling |
| **TOTAL** | **168** | **138** |  |

**Source:** *Ndejje Health center 1V 2017*

The overall number of respondents was 138(82.1% of total population). This is a representative sample that represents the above categories of respondents.

## 3.5 Sampling Techniques and Procedure

Purposive and simple random sampling methods were used to select the study participants. The methods were used to attain consistence in obtaining participants that were representative.

Simple random sampling technique was used to select health workers and local leaders to .minimizes bias and maintains consistency in sample size selection **(**Patton (2001). In addition, it helps in obtaining representative samples in relation to the behavioral domain under investigation. A list of names of local council leaders and health workers was obtained and written on a piece of paper. Each was assigned to a number. The numbers were written on pieces of paper folded and by rotary method, one was picked out at a time. The numbers picked and consequent corresponding names participated in the study.

The researcher uses judgment or handpicking regarding the participant from whom information was collected. The researcher selects samples based on his/her experience or knowledge of the group to be selected and bearing in mind that such a group has the required information. Purposive sampling is often used to select people in mandatory positions. It is often used to select participants by virtue of their. Using this purposive approach, sub county health officials and leaders who include sub county C/M, RDC and The Town Clerk were selected to participate in the study. It helps to select participants who have wide array of information on the problem of investigation.

## 3.6 Data Collection Methods

The study used questionnaires, interviews and document review. These data collection methods elicited information on good governance and performance of health centers using Ndejje health Centre IV as a case in Wakiso district local government.

### 3.6.1 Questionnaire Survey

A Questionnaire survey was deemed suitable because it has the advantage of enabling respondents to give opinions objectively without prejudice. Emotional effects such as shyness are minimized. They also have the advantage of collecting data from a big population over a short time. A questionnaire was used to collect data from respondents and it ensured gathering of first-hand information in a short period of time (Amin, 2005). Before administering questionnaires however, they were pretested to make sure that they were easily understood by the respondents. The questionnaire was administered because the number of respondents was large hence it was most convenient and cheapest means of collecting data in this case.

Additionally, questionnaires were flexible in soliciting a variety of primary data, were inexpensive to develop and solicited for information faster. The responses and observations from the questionnaire were summarized and displayed in a table from which conclusions were made.

### 3.6.2 Face to Face Interviews

The researcher used an interview guide to collect data from key informants. This enabled the researcher to collect in-depth information including one that could not be observed by the researcher. This instrument gave an opportunity to the researcher to revisit issues that were taken as oversight in other data collection instruments despite the fact that they were important for the study. This was intended to elicit a wide view on the subject. This involved face to face conversations that was guided by the interview topical guide to maintain consistence and ensure all issues were covered.

**3.6.3 Documentary Review**

Documentary review involved extracting information from documents. It is primarily used for secondary data. Information was gathered from documents on good governance of Ndejje health centre and health performance. The documents helped to give a vivid picture of the situation under investigating on as this helps to cross check information and data in a more realistic manner for purposes of triangulation (Desncombe, 2008). These documents were useful in the research design and also provided baseline data in which the study was anchored (Amin 2005).The document reviewed included unpublished and published reports like MoH Reports, and Ndejje Health Centre Reports.

## 3.7 Data Collection Instruments

The study used a structured questionnaire, interview guide and a documentary check list to collect data.

### 3.7.1 Questionnaires

The questionnaires comprised close- ended items accompanied by a list of possible alternatives from which respondents were requested to select the answers that best described their opinion about the problem of investigation and situation (Mugenda & Mugenda, 2010). The questionnaires were standardized and rigid allowing no flexibility to the answers of the items set in the questionnaire. This facilitated to enlist validity and control of the extraneous variables (Sarantakos, 2005).

A structured questionnaire containing sections as per study variables was designed to collect data on the study problem. It was administered to health workers and local council leaders. It had a five point Likert scale with response choices such as: (1) strongly Agree, (2) Agree, (3) Not sure, (4) Disagree, (5) Strongly Disagree. The Likert format was preferred because it gives the respondents a variety of responses for choice and the format also makes it easy to tabulate the data obtained for comparison purposes.

### 3.7.2 Interview Guide

The interview topical guide was designed to collect data. This guide helped to maintain consistency. The interviews were preferred to give the top management who are an informed category by virtue of their offices wide latitude to talk about the subject at length without limit. This was administered to the CAO, LC V C/M. DHO, RDC and in charge of Ndejje health centre IV

### 3.7.3 Documentary Review Check List

A documentary review check list was designed to extract the necessary data from the documents. These included meetings, reporting and policies regarding good governance. It also captured information about health unit performance such as client satisfaction and availability of staff at the facility. These documents were useful in the research design and also provided baseline data in which the study was anchored (Amin 2005). The document reviewed included unpublished and published reports like MoH Reports, and Ndejje Health Centre Reports.

## 3.8 Validity and Reliability of Research Instrument

**Validity**

According to Amin (2005), validity refers to the appropriateness of the instrument. It is the ability to produce findings that are in agreement with theoretical and conceptual values of the study. It is the ability to produce accurate results and measure what it is supposed to measure. To ensure validity of research instruments, copies of the draft instruments were pilot tested in Kasangati Health Centre IV. This was selected because it has more or less similar characteristics with Ndejje health since they are all at the same level and in Wakiso district. This helped to assess the language clarity, ability to tap information needed, acceptability in terms of length and the privacy of the respondents. The researcher further discussed the instruments with the research supervisor, academic staff and other colleagues. Thereafter, validity was established by computing the content validity index whose formula is;

 CVI = K/N

Where by’ CVI= Content Validity Index

 K =Number of items considered relevant/suitable

 N = Number of items considered in the instruments

Four experts were requested to rate the instruments. Two of them were colleagues pursuing master of management studies while the other two were in the field of Administration at the education level of Masters. The results from the rating were used to compute the content validity index value ration. The CVI method was preferred because it is the most suitable validity measure for the studies using instruments like questionnaires and the researcher attained .859 for health workers questionnaire and .874 for local leaders’ questionnaire which is more than 0.7 validity value ratio as recommended by (Amin 2005) ( See Appendix vi) .

Table 3. 2:Content Validity Index Test Results for the Questionnaire

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Variable | Items | Results | Judges | Relevant | Irrelevant |
| Citizen participation | 6 | 0.76 | Judge 1 | 8 | 2 |
| Transparency | 6 | 0.83 | Judge 2 | 8 | 2 |
| Accountability | 8 | 0.89 | Judge 3 | 12 | 4 |
| Performance | 5 | 0.72 | Judge 4 | 5 | 2 |

# *Source: Primary Data (2018)*

The Content validity index test was carried out and the test results revealed that citizen participation had a reliability result of .76, transparency had a reliability test result of .83, accountability had a reliability test result of .89 and lastly the dependent variable (performance) had a reliability test result of .72. All the variables had results above the standard value of .70 (70%) which showed that all items in the instruments were reliability.

# Reliability of Research Instruments

Amin (2005) defined reliability as the dependability or trustworthiness in context of measuring the instrument. It is the degree to which the instrument consistently measures what it is measuring. In order to ensure reliability, the study adopted the Cronbach’s coefficient Alpha (general form of Kunder-Richardson formula) to determine how the items correlate among themselves. Inconsistencies in the instruments were addressed accordingly in order to suit the theoretical and conceptual framework of the study. This was determined by the use of Cronbach’s Coefficient Alpha formula.



Where;

*K=* the number of components (*K-items* or *testlets*),

 =the variance of the observed total test scores, and

=the variance of component *i* for the current sample of persons.

The study attained 0.792 coefficient value ratio. This implies that the instruments were more than 70% reliable (Amin 20015).The researcher therefore went ahead to administer the instruments because of the high reliability value ratio (See appendix Vii)

Table 3. 3:Cronbach Alpha Test Results for the Questionnaire

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Variable | Items | Results | Judges | Relevant | Irrelevant |
| Citizen participation | 6 | 0.77 | Judge 1 | 7 | 1 |
| Transparency | 6 | 0.88 | Judge 2 | 8 | 2 |
| Accountability | 8 | 0.74 | Judge 3 | 10 | 2 |
| Performance | 5 | 0.83 | Judge 4 | 5 | 2 |

## Source: Primary Data (2018)

## The Cronbach Alpha Coefficient test was carried out and the test results revealed that citizen participation had a reliability result of .77, transparency had a reliability test result of .88, accountability had a reliability test result of .74 and lastly the dependent variable (performance) had a reliability test result of .83. All the variables had results above the standard value of .70 (70%) which showed that all items in the instruments were reliability

## 3.9 Procedure of Data Collection

An introduction letter was obtained from UMI to help the researcher access to the participants. The researcher personally and physically carried out the exercise of data collection without employing research assistants. No questionnaire was left behind to avoid consultation and thus biased responses. The district officials were interviewed first and finally preceded to the Ndejje health centre IV.

## 3.10 Data Analysis

Data analysis concerns the ‘breaking up’ of data in logical and manageable themes, categories, patterns, trends for reporting purposes (Creswell 2009). Data was analyzed depending on whether it was qualitative or quantitative, thus quantitative and qualitative approaches were adopted.

### 3.10.1 Quantitative Analysis

Data was coded by assigning numerals to responses. The study employed Statistical Package for Social Scientists (SPSS) and data was entered into an SPSS editor. It was edited by double entry. It was ensured that the first entry was the same as the second entry. This generated a frequency code sheet for the various responses. This was used for descriptive analysis where measures of central tendency like mean, standard deviation and percentages were computed. The inferential statistics were used where Pearson’s correlation coefficient was run to test the hypothesis to establish the relationship between the predictor independent variables and the dependent variable. Simple regression or coefficient of determination was run to establish the extent of the relationship.

### 3.10.2 Qualitative Analysis

Data from interviews was edited, coded and analyzed by categorization under the themes studied. The master sheet and content analysis approaches were used to reduce data for reporting purposes. A master sheet was used to draw frequency counts which were used to generate percentages. Direct quotations from the key informants were reported verbatim under the variable/themes studied. Data from documents were categorized and reported according to themes studied.

## 3.11 Measurement of Variables

According to Mugenda and Mugenda (2010), measurement of variables gives the research information regarding the extent of individual difference on a given variable. It’s on this basis therefore that appropriate measurements was used to measure and data was categorized in an orderly form using the five Likert scale used on the questionnaire as indicated below.

Table 3. 4:The Likert Scale

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5 | 4 | 3 | 2 | 1 |
| Strongly Agree | Agree | Not Sure  | Disagree | Strongly Disagree |

A nominal scale was used where numbers were assigned to the different variables to serve as its name and create sameness or difference. This enabled the researcher to know the difference between variables**.**

## 3.12 Ethical Considerations

Ethics are the norms or standards for conduct that distinguish between right and wrong.  They help to determine the difference between acceptable and unacceptable behaviors (Devlin, 2006). Ethical standards prevent against the fabrication or falsifying of data and therefore, promote the pursuit of knowledge and truth which is the primary goal of research (May, 2011).  Ethical behavior is also critical for collaborative work because it encourages an environment of trust, accountability and mutual respect among researchers. The handling of these ethical issues greatly impact the integrity of the research results. Honesty, objectivity, respect for intellectual property, social responsibility, confidentiality, non-discrimination and many others (May, 2011). Voluntary participation and informed consent were catered for. The purpose of the survey was fully explained and the respondents politely requested to participate in the study. According to Cohen et al. (2000), it is very important that the participants have the option to refuse to participate in the study and the researcher has to provide this option. This was provided for in the introduction part of the questionnaire and consent form. Anonymity was another concern (Deniscombe 2008). To this end, promise and principle of anonymity together with confidentiality was assured, after all, the names of the respondents were not requested. Similarly, emphasis was noted that the information would be treated in aggregate and purely for research purposes. Appreciation was ensured to the respondents and participants after data collection for ethical considerations.

# CHAPTER FOUR

# PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

## 4.1 Introduction

This chapter presents analyses and interprets the data of the study findings. The purpose of the study was to assess the relationship between good governance and performance of local government health centers   in Uganda, taking a case of Ndejje Health centre IV, in Wakiso district local government. The chapter has three sections. Sections one and two give the response rate and the demographic characteristics of the respondents respectively. The third section presents analyses and interprets data on research questions and hypothesizes which were obtained from questionnaires and interviews in line with study objectives.

## 4.2 Response Rate

The response rate for the study participants was computed and is presented in the Table 4.1.

 Table 4. 1 :Response Rate

|  |  |  |  |
| --- | --- | --- | --- |
| Data collection method | Target Response | Actual Response | Response Rate (%) |
| Questionnaire  | 130 | 110 | 84.6 |
| Interview  | 18 |  13 | 72.2 |
| Total  | 138 | 123 | 89.1 |

**Source:** *Primary Data (2018)*

According to Table 4.1, the response rate was 89% for all the participant categories selected for the study. This was an excellent response rate basing on Amin (2005) who recommends 70% response rate. The interpretation from this finding is that the responses in this study are representative in regard to the study population and sample size and can therefore be generalized for other environmental settings. The researcher exhibited patience to attain this high response rate and in addition, health workers can easily be located at the health facility and local leaders can be traced.

## 4.3 Findings on Demographic Characteristics of Respondents

Various demographic characteristics of these respondents were obtained and are detailed in the following Tables. These included: gender, age, highest level of education, marital status and working experience.

### 4.3.1 Gender

The findings on distribution of the respondents by gender are presented in Table 4.2.

Table 4. 2:Distribution of Study Participants by Gender

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category**  | **Female** (f) | **Percentage** (%) | **Male** (f) | **Percentage** (%) |
| District leaders  | 1 | 50 | 1 | 50 |
| District health officials  | 0 | 0 | 3 | 100 |
| Local leaders  | 27 | 43 | 35 | 57 |
| Health staff  | 27 | 48 | 29 | 52 |
| **Total** | **55** | **44.7** | **68** | **55.3** |

**Source:** *Primary Data (2018)*

According to Table 4.2 above, male participants constituted the majority with 55.3%, while the females were 44.7%. The general finding from this data implies that the responses are relatively balanced according to gender. Thus the views in this study are representative in regard to gender. Gender characteristics present different perceptions and appreciation of the different good governance schemes and approaches. Thus all these are catered for in the findings.

### 4.3.2 Age

The age of the respondents was another demographic element obtained from the study participants. The distribution of the age of the study participants is presented in Table 4.3.

Table 4. 3:Distribution of Study Participants by Age

|  |  |  |
| --- | --- | --- |
| Category  | Frequency | Percentage |
| 21-25  | 32 | 26 |
| 26-30  | 60 | 48.8 |
| 31-35 | 22 | 17.9 |
| 36-40 | 9 | 7.3 |
| Total | 123 | 100 |

**Source:** *Primary Data (2018)*

Table 4.3 shows, that majority of respondents (48.8 %) were aged between 31 -40 years. The least age bracket of the study participants were 7.3% in the age bracket of 50 years and above. The reason for this least age bracket is fact old people are less involved in political leadership and again, there is a tendency of early retirement among civil servants. These findings indicate that the study participants were mature and cut across the active age brackets of the civil service. This implies that the study participants were in position to give reliable and mature information. Different age groups perceive good governance differently.

### .3.3 Education Characteristics of Respondents

Education was yet another demographic characteristic considered from the study participants. The distribution of the study participants by education level is presented in Table 4.4.

Table 4. 4:Distribution of Study Participants by Highest Level of Education

|  |  |  |
| --- | --- | --- |
| Level of Education | Frequency | Percentage |
| Certificate | 39 | 31.7 |
| Diploma | 46 | 37.4 |
| Degree | 31 | 25.2 |
| Masters | 7 | 5.7 |
| Total | 123 | 100 |

##  Source: Primary Data (2018)

## Table 4.4 shows that majority of the study participants (37.4%) had diplomas while the least were those who had Masters Level of education with 5.7%. These findings indicate that the study participants had reasonably high level of education and thus able to contribute informed data to the study. Education has a bearing on interpreting good governance and health performance.

### 4.3.5 Marital Status

Furthermore, marital status was another demographic characteristic considered from the study participants. The distribution of the study participants by marital status is presented in Table 4.6

Table 4. 5:Study Participants by Marital Status

|  |  |  |
| --- | --- | --- |
| **Category**  | **Frequency**  | **Percentage** |
| Married | 88 | 71.5 |
| Single  | 23 | 18.7 |
| Widowed  | 6 | 4.9 |
| Widower | 6 | 4.9 |
| Total | 123 | 100 |

# Table 4.5 shows that majority of study participants 71.5% were married while the least study participants were the widowed and widowers 4.9% respectively. The findings in this study are thus informed by the varying marital statuses and can therefore be generalized in relation to the same.

### 4.3.6 Working Experience

Again, working experience was yet another demographic characteristic considered from the study participants. The distribution of the study participants by working experience is presented in Table 7.

Table 4. 6:Distribution of Respondents by Working Experience

|  |  |  |
| --- | --- | --- |
| **Years of Experience** | **Frequency** | **Percentage** |
| 1  | 15 | 12.5 |
| 1-5 | 65 | 52.8 |
| 5-10 | 36 | 29.3 |
| 10-15  | 6 | 4.9 |
| Total  | 123 | 100 |

Table 4.7 shows that majority of the study participants 52.8% had a working experience of 1-5yrs while the least represented working experience was that of 20 years and above (0.8%). This implies that the findings in study are premised and informed by a wealthy of varying experience. The high percentage of 1-5yeras is due to political leaders whose tenure of office in Uganda is five years from the time of election.

## 4.4 Empirical Findings

This section presents the empirical findings as established from the field. The findings are presented logically according to the study objectives and as per the method of analysis. To this end, descriptive data has been presented using frequency counts, percentages, Mean and Standard Deviation followed by qualitative data from interviews and finally testing of the hypothesis using inferential statistics.

### 4.4.1 Citizen Participation and the Performance of Ndejje Health Center

The purpose of this objective was to establish the relationship between citizen participation and the performance of Ndejje health center. The dimensions of citizen participation assessed included; citizen involvement in health planning and citizen monitoring. The findings were obtained from health workers of Ndejje health centre, local council leaders of ndejje parish and health officials. The findings on the objective are presented here under.

Table 4. 7: Descriptive Statistics of Responses on Citizen Participation and the Performance of Ndejje Health Center

|  |  |  |
| --- | --- | --- |
| **Items**  |  | **Frequencies and percentage responses=f (%)**  |
|  | **Mean** | **Std. dev** | **SA** | **A** | **NS** | **D** | **SD** |
| **Citizen Involvement in Health Planning** |  |  |  |  |  |  |  |
|  Ndejje health centre involves local people in planning for health delivery  | 3.45 | 1.66 | 40%) | 27.9% | 3.4% | 9.5% | 8.5% |
|  Ndejje health centre involves local people representative in setting health policies  | 4.40 | .98 | 45.7% | 44% | 3.3% | 5% | 1.7% |
| Ndejje health centre involves local people representatives in budgeting for health facility  | 3.31 | 1.53 | 28.8% | 25% | 2.5% | 22.8% | 20.3% |
| Ndejje health centre involves local people representatives in health staff recruitment  | 3.74 | 1.11 | 39.8% | 27.9% | 5.9% | 21.1% | 7.6% |
| Ndejje health centre involves local people representatives in human resource matters  | 4.88 | 1.31 | 78% | 26.2% | 0% | 0% | 0% |
| **Citizen Monitoring** |  |  |  |  |  |  |  |
|  Ndejje health centre involves local people representatives in cross checking health supplies received | 3.88 | 1.67 | 47.48% | 23.7% | 2.5% | 13.5% | 17.7% |
|  Ndejje health centre involves local people representatives cross check health worker behaviors  | 3.25 | .98 | 32.2% | 32.2% | 6.7% | 17.8% | 11% |
|  Ndejje health centre involves local people representatives in supervising health worker availability  | 3.55 | 1.67 | 49.4% | 24.5% | 5% | 13.5% | 7.6% |
| Ndejje health involves local people representative in evaluating health service delivery | 3.75 | 1.6.0 | 42.3% | 28.8% | 5% | 13.5% | 11.8% |
|  Ndejje health centre involves local people representatives in supervising health facility projects | 4.90 | 1.47 | 84.7% | 15.3% | 0% | 0% | 0% |

**Source:** *Primary Data N=118,*

With respect to whether Ndejje health centre involves local people in planning for health delivery, 40% strongly agree, 27.9% agreed, 3.4% were not sure, 19.5% disagreed and 8.5% strongly disagreed. The mean = 3.45 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre involves local people in planning for health delivery.

From the interviews, all the sub county leaders and health officials affirmed that good governance was in place in the provision of health services. One participant reported that;

*Ndejje health centre involves local people in planning for health delivery. The local council leaders and HUMCs are part of the health systems management including planning meetings. They have a strong stake in the functioning of the health unit including budgeting and scrutinizing expenditure.* KI parish leader

Responses to the question as to whether Ndejje health centre involves local people representative in setting health policies, 45.7% strongly agreed, 44% agreed, 3.3% were not sure, 5% disagreed and 1.7% strongly disagreed. The mean = 4.40 above the median score of three indicated that the majority agreed with the item that Ndejje health centre involves local people representative in setting health policies.

As to whether Ndejje health centre involves local people representatives in budgeting for health facility, 28.8% strongly agreed, 25%agreed, 2.5% were not sure, and 22.8% agreed and 20.3% strongly disagreed. The mean = 3.31 was above the median score, three, which on the five-point Likert scale used to measure the items indicated that Ndejje health centre involves local people representatives in budgeting for health facility.

Responses to the question as to whether Ndejje health centre involves local people representatives in health staff recruitment, 39.8%, strongly agreed, 27.9% agreed, 5.9% were not sure, 21.1% disagreed and 7.6% strongly disagreed. The mean = 3.74 above the median score of three indicated that Ndejje health centre involves local people representatives in health staff recruitment.

A respondent in contrast said that

*Ndejje health centre does not always involve local people representatives in health staff recruitment. The issue of recruitment is a matter handled by the HR.*

With respect to whether Ndejje health centre involves local people representatives in human resource matters, 78% strongly agreed, 26.2% agreed, 00% were not sure, 00% disagreed and 00% strongly disagreed. The mean = 4.88 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre involves local people representatives in human resource matters.

Responses to the question as to whether Ndejje health centre involves local people representatives in cross checking health supplies received, 47.48%, strongly agreed, 23.7%agreed, 2.5% were not sure, 13.5% disagreed and 17.7% strongly disagreed. The mean = 3.88 above the median score of three indicated that Ndejje health centre involves local people representatives in cross checking health supplies received.

With respect to whether Ndejje health centre involves local people representatives cross check health worker behaviors, 32.2% strongly, 32.2% agreed, 6.7% were not sure, 17.8% disagreed and 11% strongly disagreed. The mean = 3.25 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre involves local people representatives cross check health worker behaviors.

A respondent said that

*local people representatives cross check health worker behaviors but this is always a matter of ethics. It may not be the case all the time.*

As to whether Ndejje health centre involves local people representatives in supervising health worker availability, 49.4% strongly agreed, 24.5% agreed, 5% were not sure, 13.5% agreed and 7.6% strongly disagreed. The mean = 3.55 was above the median score, three, which on the five-point Likert scale used to measure the items indicated that Ndejje health centre involves local people representatives in supervising health worker availability.

 A participant referring to the constitution of Uganda Article candidly affirmed that

*health centre involves local people representatives in supervising health worker availability*. *On the other hand*, *decentralization strongly espouses that power belong to the people. Since power belongs to the people it implies that it attracts good governance which premises on citizen participation through monitoring and oversight supervision. This has been strongly encapsulated through local decentralized local leadership and elections*. parish leader

As to whether Ndejje health involves local people representative in evaluating health service delivery, cumulatively the majority percentage (13.5%) of the respondents disagreed with 34% agreed and 5% were not sure. The mean = 3.75 was close to four meaning that the majority of the respondents agreed with the item hence this suggested that Ndejje health involves local people representative in evaluating health service delivery.

Responses to the question as to whether Ndejje health centre involves local people representatives in supervising health facility projects, 84.7%, strongly agreed, 15.3%agreed, 00% were not sure, 00% disagreed and 600% strongly disagreed. The mean = 4.90 above the median score of three indicated that Ndejje health centre involves local people representatives in supervising health facility projects.

Yet another participant emphatically stated

*Ndejje health centre involves local people representatives in supervising health facility projects. The local leaders influence positively how services can be provided. In local councils they present areas where gaps exist in health service provision. Health service providers are mandatorily required to attend local councils. These address any queries about service delivery if any raised in the meetings*. parish official

The participants reported that citizen participation improves health service delivery and it was revealed that it is a means of empowering the citizenry in determining the services. It was mentioned that increased people’s participation in planning as well as decision making promoted local development management.

From the interviews the participants mentioned that through governance citizens monitor the provision of services or implementation of projects in their area. It was affirmed that the scope of responsibility of local councils is wide and to be more effective, councils involve Non-Governmental Organizations, Community Based Organizations and the Private sector in the management of community affairs. Through participation, citizens enjoy a high quality of life and are capable of asserting their rights, determining their local development agenda and discharging their obligations in national development.

In relation to the above sentiments, a key informant remarked thus;

*ya….decentralization was a way of the state providing multiple centers of participation in decision-making that in turn assures better management and responsiveness in health provision. Local people have various avenues of participation in health provision including local councils, HUMCs where they provide oversight monitoring*. parish leader

In addition, the results show that the mean from the responses are close to the maximum and above average. This means that the respondents were highly in agreement that good governance improves health performance. The standard deviations show a low variation from the mean. This implies that the respondent’s opinions do not vary on good governance and health performance. The interpretation from this finding is that local leaders do not vary on centrality of good governance in health performance at Ndejje health centre IV.

**Testing the Hypothesis**

The alternative hypothesis was tested using person correlation coefficient to establish the relationship between the independent and dependent variable. In addition R was squared to obtain coefficient of determination to ascertain the extent of covariance of the predictor independent variable on the dependent variable. The findings are presented in the following tables.

Table 4. 8:Showing Correlation between Citizen Participation and Health Performance at Ndejje health centre IV

|  | Citizen participation  | Health performance  |
| --- | --- | --- |
| Citizen participation  | Pearson Correlation | 1 | 511\* |
| Sig. (2-tailed) |  | .000 |
| N | 123 | 123 |
|  Health Performance  | Pearson Correlation | .511\*\* | 1 |
| Sig. (2-tailed) | .000 |  |
| N | 123 | 123 |
| \*. Correlation is significant at the 0.05 level (2-tailed). |

The result in Table 4.8 showed that the correlation coefficient is .511\* at a P value =0.000 which was less than the significance level of 0.05. This implied that citizen participation significantly affects health performance. Therefore the relationship between citizen participation and health performance is statistically significant. Therefore, the alternative hypothesis that was earlier stated in chapter one is upheld. The correlation coefficient is a numerical way to quantify the relationship between two variables i.e the independent and dependent and it is denoted by the symbol R. The correlation coefficient is always between -1 and 1, thus -1 < R < 1. The hypothesis is rejected if the earlier hypothesis was alternate and the finally tested hypothesis is null and the vice versa. Example if the calculated value is greater than the P value we accept the hypothesis..

A regression analysis was further conducted to ascertain the percentage of the influence and the results are shown in Table 4.9

Table 4. 9:Model Summary of Citizen Participation and Health Performance

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
| --- | --- | --- | --- | --- |
| 1 | .511a | .261 | .251 | .592 |
| a. Predictors: (Constant), Citizen Participation  |

The Model Summary Table 4.9 reveals that all the other predictors of health performance at Ndejje health centre Iv were held constant and the relationship was explained by citizen participation. A correlation coefficient *(R),* using the predictor; citizen participation, is .511 and the *R2*is equal to .261. The R square value gives the proportion of variance between the two variables (Amin, 2005). This implies that 26.1% (.511\*100%) variations in health performance at Ndejje health centre is explained by citizen participation, while the remaining percentage of variations can be explained by other factors. The interpretation from this finding is that citizen participation contributes immensely to and health performance as perceived by local leaders

### 4.4.2 Transparency and Health Performance

The purpose of the objective was to establish the relationship between transparency health performances. The dimensions of transparency assessed were accessibility to health information and reporting of health information. These were assessed using descriptive statistics, qualitative data and inferential statistics using Pearson(r). The findings are presented in the following Tables.

Table 4. 10:Descriptive Statistics of Responses Transparency and Health Performance

|  |  |  |
| --- | --- | --- |
| **Items**  |  | **Frequencies and percentage responses (%)**  |
|  | **Mean** | **Std. dev** | **SA** | **A** | **NS** | **D** | **SD** |
| Accessibility to health information |
| Ndejje health centre communicates openly performance to stakeholders  | 4.06 | 1.49 | 61(45.2%) | 32(33.9%) | 5 (4.2% | 5(40.2%) | 15(19.3%) |
| Ndejje health centre allows stakeholders access to health facility information  | 4.80 | .398 | 50.88% | 42.3% | 5% | 0.8% | 0.8% |
|  Ndejje health centre uses the available networks to avail user system health facility information  | 3.33 | 1.27 | 22.2% | 30.5% | 5% | 13.5% | 16.1% |
|  Ndejje health centre user system are empowered to demand for health service information  | 3.90 | 1.27 | 44.44% | 27.9% | 5% | 5% | 13.5% |
| **Reporting of health information**  |
| Ndejje health centre reports health gains to stakeholders | 4.08 | 1.49 | 35.5% | 44% | 5.9% | 9.3% | 5% |
|  Ndejje health centre reports has appropriate avenues for reporting  | 4.46 | 1.50 | 52.5% | 35.6% | 3.4% | 7.6% | 0.8% |
|  Ndejje health centre reports all its obligations  | 4.55 | 1.64 | 42.3% | 45.7% | 1.7% | 5.9% | 5(4.2%) |
| Ndejje health centre reports accordingly  | 4.84 | 1.21 | 90.3% | 9.7% | 0% | 0% | 0(0%) |

**Source:** *Primary Data (2018)*

With respect to whether Ndejje health centre communicates openly performance to stakeholders, 45.2% strongly, 33.9% agreed, 4.2% were not sure, 40.2% disagreed and 19.3% strongly disagreed. The mean = 4.06 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre communicates openly performance to stakeholders.

A respondent noted that

 *Ndejje health centre communicates openly performance to stakeholders; however this does not apply to all cases. It is in a few instances.*

 Responses to the question as to whether Ndejje health centre allows stakeholders access to health facility information, 50.88% strongly agreed, 42.3% agreed, 5% were not sure, 0.8% disagreed and 0.8% strongly disagreed. The mean = 4.80 above the median score of three indicated that the majority agreed with the item that Ndejje health centre allows stakeholders access to health facility information

As to whether Ndejje health centre uses the available networks to avail user system health facility information, 22.6% strongly agreed, 30.5%agreed, 5% were not sure, and 13.5% strongly disagreed. The mean = 3.33 was above the median score, three, which on the five-point Likert scale used to measure the items indicated that Ndejje health centre uses the available networks to avail user system health facility information.

A respondent noted

*Ndejje health centre uses the available networks to avail user system health facility information. The network sometimes is not definitive and this entails a lot of intricacies*.

 Responses to the question as to whether Ndejje health centre user system are empowered to demand for health service information , 44.4%, strongly agreed, 27.9%agreed, 5% were not sure, 5% disagreed and 13.5% strongly disagreed. The mean = 3.90 above the median score of three indicated that Ndejje health centre user system are empowered to demand for health service information.

With respect to whether Ndejje health centre reports health gains to stakeholders, 38.7% strongly agreed, 35.5% agreed, 44% were not sure, 5.9% disagreed and 5% strongly disagreed. The mean = 4.08 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre reports health gains to stakeholders.

 One of the key informants noted thus:

*Ndejje health centre reports health gains to stakeholders. One of the health representative usually the in charge has to attend council meeting where he reports all what is taking place at the health unit. He is also obliged to make reports to Ndejje Sub County and the Waksio district as well giving the health study at the facility*. Key informant Ndejje Health Unit

From the document review it was established that the health unit has HMIS record form where all health interventions are recorded. Similarly, receipt of medical drugs and supplies are recorded. The HUMCs records were available but scanty. Their meetings were reported irregular due to lack of seating allowances

Responses to the question as to whether Ndejje health centre reports has appropriate avenues for reporting, 52.5%, strongly agreed, 35.6%agreed, 3.4% were not sure, 7.6% disagreed and 0.8% strongly disagreed. The mean = 4.46 above the median score of three indicated that Ndejje health centre reports has appropriate avenues for reporting.

With respect to whether Ndejje health centre reports all its obligations, 42.3% strongly, 45.7% agreed, 1.7% were not sure, 5.9% disagreed and 4.2% strongly disagreed. The mean = 4.54 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre reports all its obligations.

A Sub county chief noted that

 *Ndejje health centre reports all its obligations, however it is only the administration that handles such matters in the health centre.*

With respect to whether Ndejje health centre reports accordingly, 90.3% strongly agreed, and 9.7% agreed. The mean = 4.84 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre reports accordingly.

 Findings from interviews showed that openness in local decentralized government demonstrate that they are acting in the public interest at all times and to maintain public trust and confidence. The findings further showed that health facilities are open as possible about all their decisions, actions, plans, resource use, forecasts, outputs, and outcomes. Ideally, this commitment is documented through a formal policy on openness of information. Health workers and governing bodies like HUMCs and local councils provide clear reasoning for their decisions. In both their public records of decisions and in explaining them to stakeholders, they are explicit about the criteria, rationale and considerations on which decisions are based, and, in due course, about the impact and consequences of those decisions. The finding further showed that Ndejje health facility does not restrict the provision of information when the wider public interest clearly demands it.

The findings further show that all the means computed from the responses are above the average implying that the respondents agreed that there is a relationship between transparency and health performance at Ndejje Health centre IV. Again the standard deviations don’t show paramount deviations. This indicates that the respondent’s views don’t vary between transparency and health performance. This implies that respondents are in agreement that transparency influences health performance.

From the interviews, the findings revealed that reporting exposes any fraud and the stake holders get the basis from where to ensure transparency. They mentioned that information was critical health service provision. It keeps the users aware of the supplies and thus creates demand of the services. Similarly, the key informants mentioned that when information is available, the health providers are obliged to supply services accordingly.

***Tests of Research Hypothesis***

The hypothesis was tested using Pearson correlation coefficient. Coefficient of determination (r2) was calculated to determine the extent of the relationship.

Table 4. 11:Correlation between Transparency and Health Performance at Ndejje Health Centre iv

|  | Transparency  | Health Performance  |
| --- | --- | --- |
| Transparency  | Pearson Correlation | 1 | .522\* |
| Sig. (2-tailed) |  | .000 |
| N | 123 | 123 |
| Health Performance  | Pearson Correlation | .522\* | 1 |
| Sig. (2-tailed) | .000 |  |
| N | 123 | 123 |
| \*. Correlation is significant at the 0.05 level (2-tailed). |

The result in Table 4.11 showed that the correlation coefficient is .522\* at a P value =0.000 which was less than the significance level of 0.05. This implied that there is a significant positive relationship between transparency and Health Performance at Ndejje Health Centre. Therefore the relationship between transparency and Health Performance at Ndejje Health Centre is statistically significant. Therefore, the alternative hypothesis that was earlier stated in chapter one is upheld. The correlation coefficient is a numerical way to quantify the relationship between two variables i.e the independent and dependent and it is denoted by the symbol R. The correlation coefficient is always between -1 and 1, thus -1 < R < 1. The hypothesis is rejected if the earlier hypothesis was alternate and the finally tested hypothesis is null and the vice versa. Example if the calculated value is greater than the P value we accept the hypothesis.

A regression analysis was further conducted to ascertain the percentage of the influence and proportion of variance between the predictor independent variable and the dependent variable. the results are shown in Table 4.12

Table 4. 12:Model Summary of Transparency and Health Performance at Ndejje Health Centre Iiv

|  |
| --- |
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
| 1 | .522a |  .272 | .261 | .411 |
| a. Predictors: (Constant), transparency  |

The Model Summary table 4.12 reveals that all the other predictors of health performance at Ndejje health centre IV were held constant and the relationship was explained by transparency. A correlation coefficient *(R),* using the predictor transparency, is .522 and the *R2*is equal to .272. The R square value gives the proportion of variance between the two variables (Amin, 2005). This implies that 27.2% (.522\*100%) variations in health performance at Ndejje health centre IV is explained by transparency, while the remaining percentage of variations can be explained by other factors.

#### 4.4.3 Accountability and Performance of Ndejje Health Centre

The purpose of the objective was to establish the relationship between accountability and health performance. The dimensions of accountability assessed were enforcing rules and public expenditure tracking reporting of health information. These were assessed using descriptive statistics, qualitative data and inferential statistics using Pearson(r). The findings are presented in the following Tables.

Table 4. 13:Descriptive Statistics of Responses on Accountability and Ndejje Health Centre Performance

|  |  |  |
| --- | --- | --- |
| **Items**  |  | **Frequencies and percentage responses =f (%)**  |
|  | **Mean** | **Std. dev** | **SA** | **A** | **NS** | **D** | **SD** |
| **Enforcing Rules** |  |  |  |  |  |  |  |
|  Ndejje health centre explains all action taken to stakeholders | 4.75 | 1.47 | 80.7% | 19.3% | 2.5% | 0% | 0% |
| Ndejje health center stakeholders enforce standards in the health facility | 4.96 | 1.23 | 90% | 0% | 0% | 0% | 0% |
| Ndejje health centre has checked corruption  | 4.45 | 1.83 | 68.9% | 20.3% | 3.3% | 5% | 0% |
|  Ndejje health centre has procedures for stakeholders to reprimand accountability | 4.55 | 1.08 | 78.8% | 19.4% | 4.2% | 4.2% | 1.7% |
| Ndejje health centre there is value for money M | 3.57 | 1.83 | 37.3% | 30.5% | 11% | 8.4% | 12.9% |
| **Public Expenditure Tracking** |
|  Ndejje health centre has PETS in place that minimize leakage and lead to appropriate use of funds. | 3.88 | 1.49 | 30.5% | 42.3% | 3.3% | 11(9.3%) | 8(6.7%) |
| Ndejje health centre publishes the receipt of funds in open for public to view | 4.14 | 1.48 | 58% | 327.9% | 5% | 3.3% | 16(13.5%) |
|  Ndejje health centre publishes the expenditure of funds in open for public to view | 4.99 | .497 | 00% | 0% | 0% | 0% | 0(0%) |
| Ndejje health centre calls for stakeholder meeting to present accountability  | 4.88 | 1.48 | 68.6% | 9.6% | 5% | 0% | 0(0%) |

 With respect to whether Ndejje health centre explains all action taken to stakeholders, 80.7% strongly, 19.3% agreed, 2.5% were not sure, 00% disagreed and 00% strongly disagreed. The mean = 4.75 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre explains all action taken to stakeholders.

A District Staff noted that

*Ndejje health centre explains all action taken to stakeholders but this is in a few cases which may be deemed relevant to the stakeholders.*

Responses to the question as to whether Ndejje health center stakeholders enforce standards in the health facility, 90% strongly agreed, and 10% agreed. The mean = 4.96 above the median score of three indicated that the majority agreed with the item that Ndejje health center stakeholders enforce standards in the health facility.

A Sub county chief said that

*Ndejje health center stakeholders enforcing standards in the health facility is very relative and may not apply in all instances*

As to whether Ndejje health centre has checked corruption, 68.9% strongly agreed, 20.3% agreed, 3.3% were not sure, and 5% strongly disagreed. The mean = 4.45 was above the median score, three, which on the five-point Likert scale used to measure the items indicated that Ndejje health centre has checked corruption.

A health worker pointed out that

*Ndejje health centre has checked corruption although there are still instances where some health officials have secretly got invoved in corruption.*

 Responses to the question as to whether Ndejje health centre has procedures for stakeholders to reprimand accountability, 78.8%, strongly agreed, 19.4%agreed, 4.2% were not sure, 4.2% disagreed and 1.7% strongly disagreed. The mean = 4.55 above the median score of three indicated that Ndejje health centre has procedures for stakeholders to reprimand accountability.

As to whether in Ndejje health centre there is value for money, 37.3% strongly agreed, 30.5%agreed, 11% were not sure, and 8.4% strongly disagreed. The mean = 3.57 was above the median score, three, which on the five-point Likert scale used to measure the items indicated that Ndejje health centre there is value for money.

A respondent relatedly noted that

*Ndejje health centre attached value for money on most of the cases handled by the health centre. For example treatment, sanitation and cleaniliness.*

Responses to the question as to whether Ndejje health centre has PETS in place that minimize leakage and lead to appropriate use of funds, 30.5%, strongly agreed, 42.3%agreed, 3.3% were not sure, 9.3% disagreed and 6.7% strongly disagreed. The mean = 3.88 above the median score of three indicated that Ndejje health centre has PETS in place that minimize leakage and lead to appropriate use of funds.

With respect to whether Ndejje health centre publishes the receipt of funds in open for public to view, 58% agreed, 5% were not sure, 3.3% disagreed and 13.5% strongly disagreed. The mean = 3.96 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre publishes the receipt of funds in open for public to view.

Yet another participant explicitly affirmed that:

 *The health units as a requirement have to announce the receipts of funds they receive. Similarly they have to justify the expenditure. Politicians and councilors have the in the duty during meeting to reprimand health workers who don’t comply. Similarly when the user system is not satisfied they forward the matter to the local leaders for action K I*

Responses to the question as to whether Ndejje health centre publishes the expenditure of funds in open for public to view, 100%, strongly agreed. The mean = 4.99 above the median score of three indicated that Ndejje health centre publishes the expenditure of funds in open for public to view.

With respect to whether Ndejje health centre calls for stakeholder meeting to present accountability, 68.6% strongly, 29.6% agreed, 5% were not sure, 0% disagreed and 0% strongly disagreed. The mean = 4.88 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health centre calls for stakeholder meeting to present accountability.

The participants expressed the other ideas in the following quotations.

*in case, there is anything we need a decision or policy as, we sit as a sub district health management team and request the health in charge to* explain all action taken to stakeholders *and in case it not within the standards requires and is in bleach, then we forward the matter to the DHO, C/M LC V and CAO who tables the issue to the district council sectoral committee, executive and finally to district council for actin”*KI

Another participant candidly mentioned

*“Decentralization has fostered better supervision of facilities which enables* stakeholders enforce standards in the health*. The health providers are now answerable to the people through the HUMCS and local council leaders. They justify actions and this fosters good governance and accountability. KI*

The key informants affirmed that having a strong system of financial management for accountability underpins sustainable decision making, delivery of services, and achievement of outcomes in public sector entities, as all decisions and activities have direct or indirect financial consequences.

The key informants revealed that The Public sector entities and Ndejje in particular ensure that their financial management supports both long-term achievement of outcomes and short-term financial and operational performance. A sustainable public sector entity will have well-developed financial management integrated at all organizational levels of planning and control, including management of financial investments.

The key informants mentioned that there are now many different channels the health sector entities to use to communicate with their stakeholders, including web-based information and social media. In providing information, a balance needs to be struck so that the right amount of information is provided through appropriate channels of communication to satisfy accountability. It was established that public scrutiny creates a demand for accountability improved service delivery and so its influence can help to build pressure for a more open, honest, and, ultimately, more effective public sector. They can be formal, such as a through a formal legislature committee as HUMC, or informal, such as via the media.

The findings revealed that decentralization has led local policy formulation in health service delivery quite easier which fosters accountability.

From documents accountability reports for financial expenditure and medical drugs and supplies were identified. These are sent to sub county council and district. The interpretation from these finding is that every action has to be justified accordingly.

 Looking at the public expenditure tracking dimension, 3630.5%)and 57(42.32%)strongly agreed and agreed that Ndejje health centre have PETS in place that minimize leakage and lead to appropriate use of funds while only 5(2.5%were not sure, 11(9.3%)disagreed and 8(6.7%)strongly disagreed. About whether Ndejje health centre publishes the receipt of funds in open for public to view, 59(58%) and 33(27.9%) strongly agreed and agreed respectively with view while 3(4.8%) were not sure, 4(6.5%) disagreed and 10(16.1% strongly disagreed. When the respondents were asked whether Ndejje health centre publishes the expenditure of funds in open for public to view all 118(100%) strongly agreed. About whether Ndejje health centre calls for stakeholder meeting to present accountability 81(68.6%) and 35(29.6%) strongly greed an agreed respectively while 6(5%) were not sure none disagreed and strongly disagreed respectively. The interpretation from this finding is that public expenditure tracking is in place. The general interpretation on the objective and research question is that there are accountability mechanisms in place at Ndejje health centre IV.

The findings further show that all the means computed from the responses are above the average implying that the respondents agreed that there is a relationship between accountability and health performance at Ndejje Health centee IV. Again the standard deviations don’t show paramount deviations. This indicates that the respondent’s views don’t vary between accountability and health performance at Ndejje health centre IV. This implies that respondents are in agreement that there is a relationship between accountability and health performance.

Table 4. 14:Descriptive Statistics of Responses on Performance

|  |  |  |
| --- | --- | --- |
| **Items**  |  | **Frequencies and percentage responses (%)**  |
|  | **Mean** | **Std. dev** | **SA** | **A** | **NS** | **D** | **SD** |
|  |
| The health facility utilization is productive | 4.06 | 1.49 | 61(45.2%) | 32(33.9%) | 5 (4.2% | 5(40.2%) | 15(19.3%) |
| Ndejje health centre has adequate staff | 4.80 | .398 | 50.88% | 42.3% | 5% | 0.8% | 0.8% |
|  There is availability of staff at Ndejje health centre | 3.33 | 1.27 | 22.2% | 30.5% | 5% | 13.5% | 16.1% |
|  Ndejje health centre staff have positive attitude towards patients | 3.90 | 1.27 | 44.44% | 27.9% | 5% | 5% | 13.5% |
|  |
| Ndejje health staff are committed to health provision | 4.08 | 1.49 | 35.5% | 44% | 5.9% | 9.3% | 5% |
|  Health infrastructure is well renovated | 4.46 | 1.50 | 52.5% | 35.6% | 3.4% | 7.6% | 0.8% |
|  There is general Cleanliness  | 4.55 | 1.64 | 42.3% | 45.7% | 1.7% | 5.9% | 5(4.2%) |
| There is client satisfaction  | 4.84 | 1.21 | 90.3% | 9.7% | 0% | 0% | 0(0%) |

**Source:** *Primary Data (2018)*

With respect to whether the health facility utilization is productive, 45.2% strongly, 33.9% agreed, 4.2% were not sure, 40.2% disagreed and 19.3% strongly disagreed. The mean = 4.06 which corresponded to agreed indicated the majority of the respondents agreed that the health facility utilization is productive. Responses to the question as to whether Ndejje health centre has adequate staff, 50.88% strongly agreed, 42.3% agreed, 5% were not sure, 0.8% disagreed and 0.8% strongly disagreed. The mean = 4.80 above the median score of three indicated that the majority agreed with the item that Ndejje health centre has adequate staff.

As to whether there is availability of staff at Ndejje health centre, 22.6% strongly agreed, 30.5%agreed, 5% were not sure, and 13.5% strongly disagreed. The mean = 3.33 was above the median score, three, which on the five-point Likert scale used to measure the items indicated that there is availability of staff at Ndejje health centre.

Responses to the question as to whether Ndejje health centre staff have positive attitude towards patients, 44.4%, strongly agreed, 27.9%agreed, 5% were not sure, 5% disagreed and 13.5% strongly disagreed. The mean = 3.90 above the median score of three indicated that Ndejje health centre staff have positive attitude towards patients. With respect to whether Ndejje health staff are committed to health provision, 38.7% strongly agreed, 35.5% agreed, 44% were not sure, 5.9% disagreed and 5% strongly disagreed. The mean = 4.08 which corresponded to agreed indicated the majority of the respondents agreed that Ndejje health staff are committed to health provision.

 Responses to the question as to whether Health infrastructure is well renovated, 52.5%, strongly agreed, 35.6%agreed, 3.4% were not sure, 7.6% disagreed and 0.8% strongly disagreed. The mean = 4.46 above the median score of three indicated that Health infrastructure is well renovated. With respect to whether there is general Cleanliness, 42.3% strongly, 45.7% agreed, 1.7% were not sure, 5.9% disagreed and 4.2% strongly disagreed. The mean = 4.54 which corresponded to agreed indicated the majority of the respondents agreed that there is general Cleanliness. With respect to whether there is client satisfaction, 90.3% strongly agreed, and 9.7% agreed. The mean = 4.84 which corresponded to agreed indicated the majority of the respondents agreed that there is client satisfaction.

 *Testing the Research Hypothesis*

The hypothesis was tested using Pearson correlation coefficient. Coefficient of determination (r2) was calculated to determine the extent of the relationship. The findings are presented in the following Tables.

The relationship was tested using responses from the local leaders and the findings are presented in Table 4.15

Table 4. 15:Showing Correlation between Accountability and Health Performance at Ndejje Center

|  | Accountability  | Health performance  |
| --- | --- | --- |
| Accountability  | Pearson Correlation | 1 | .483\*\*\* |
| Sig. (2-tailed) |  | .020 |
| N | 123 | 123 |
|  Health Performance | Pearson Correlation | .483\*\*\* | 1 |
| Sig. (2-tailed) | .00 |  |
| N | 123 | 123 |
| \*. Correlation is significant at the 0.05 level (2-tailed). |

The result in Table 4.15 showed that the correlation coefficient is .483\*\*\* at a P value =0.020 which was less than the significance level of 0.05. This implied that there is a significant positive relationship between accountability and health performance. Therefore the relationship between relationship between accountability and health performance is statistically significant. Therefore, the alternative hypothesis that was earlier stated in chapter one is upheld. The correlation coefficient is a numerical way to quantify the relationship between two variables i.e the independent and dependent and it is denoted by the symbol R. The correlation coefficient is always between -1 and 1, thus -1 < R < 1. The hypothesis is rejected if the earlier hypothesis was alternate and the finally tested hypothesis is null and the vice versa. Example if the calculated value is greater than the P value we accept the hypothesis.

A regression analysis was further conducted to ascertain the percentage of the influence and the results are shown in Table 4.21;

Table 4.16:Model Summary of the relationship between Accountability and Health Performance at Ndejje health centre IV

|  |
| --- |
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
| 1 | .483a | .233 | .222 | .192 |
| a. Predictors: (Constant), Accountability  |

The Model Summary Table 4.16 reveals that all the other predictors of health performance at Ndejje health centre IV were held constant and the relationship was explained by accountability . A correlation coefficient *(R),* using the predictor; accountability, is .483 and the *R2*is equal to .233. The R square value gives the proportion of variance between the two variables (Amin, 2005). This implies that 23.3% (.233\*100%) variations in health performance at Ndejje health centre IV is explained by accountability while the remaining percentage of variations can be explained by other factors. The interpretation from this finding is that accountability contributes a reasonable proportion to health performance at Ndejje health centre IV

# CHAPTER FIVE

# SUMMARY, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

## 5.1 Introduction

This chapter provides the summary and discussion of the study findings on the relationship between good governance and performance of health centers   in Uganda, taking a case of Ndejje Health centre IV, in Wakiso district. The summary of the findings flow from the entire responses as obtained from the respondents. The discussion has been presented according to research questions and hypotheses in line with the study objectives. It is on the basis of the summary and the discussion that conclusions and recommendations are made. Areas for further research and contribution to knowledge are suggested at the end.

## 5.2 Summary of Findings

### 5.2.1 Citizen Participation and Performance of Ndejje Health Centre

The Pearson correlation coefficient showed that the correlation coefficient is .511\* at a P value =0.000 which was less than the significance level of 0.05. This implied that citizen participation significantly affects health performance. Therefore the relationship between citizen participation and health performance is statistically significant. Therefore, the alternative hypothesis that was earlier stated in chapter one is upheld.

The Model Summary for the regression revealed that all the other predictors of health performance at Ndejje health centre Iv were held constant and the relationship was explained by citizen participation. A correlation coefficient (R), using the predictor; citizen participation, is .511 and the R2is equal to .261. The R square value gives the proportion of variance between the two variables (Amin, 2005). This implies that 26.1% (.511\*100%) variations in health performance at Ndejje health centre is explained by citizen participation, while the remaining percentage of variations can be explained by other factors.

# The findings revealed that Ndejje health centre involves local people in planning for health delivery, that it involves local people representatives in setting health policies, and that it involves local people representatives in budgeting for health facility. In addition the findings revealed that the health centre involves local people representatives health staff recruitment and that it involves local people representatives in human resource matters.

# The findings showed that Ndejje health centre involves local people representatives in cross checking health supplies received, that local people representatives cross check health worker behaviors and that it involves local people representatives in supervising health worker availability. The findings also revealed that the health centre involves local people representative in evaluating health service delivery and that it involves local people representatives in supervising health facility projects.

### 5.2.2 Transparency and Performance of Ndejje Health Centre

The Pearson correlation coefficient showed that the correlation coefficient is .522\* at a P value =0.000 which was less than the significance level of 0.05. This implied that there is a significant positive relationship between transparency and Health Performance at Ndejje Health Centre. Therefore the relationship between transparency and Health Performance at Ndejje Health Centre is statistically significant. Therefore, the alternative hypothesis that was earlier stated in chapter one is upheld. The Model Summary for the regression revealed that all the other predictors of health performance at Ndejje health centre IV were held constant and the relationship was explained by transparency. A correlation coefficient (R), using the predictor transparency, is .522 and the R2is equal to .272. The R square value gives the proportion of variance between the two variables (Amin, 2005). This implies that 27.2% (.522\*100%) variations in health performance at Ndejje health centre IV is explained by transparency, while the remaining percentage of variations can be explained by other factors.

The study results showed that Ndejje health centre communicates openly its performance to stakeholders that it allows stakeholders access to health facility information, that it uses the available networks to avail user system health facility information and that user system are empowered to demand for health service information.

# The field survey results indicated that Ndejje health centre reports health gains to stakeholders, that it has appropriate avenues for reporting, that it reports all its obligations and finally that it reports health matters to relevant offices accordingly.

### 5.2.3 Accountability and Performance of Ndejje Health Centre

The Pearson correlation coefficient showed that the correlation coefficient is .483\*\*\* at a P value =0.020 which was less than the significance level of 0.05. This implied that there is a significant positive relationship between accountability and health performance. Therefore the relationship between relationship between accountability and health performance is statistically significant. Therefore, the alternative hypothesis that was earlier stated in chapter one is upheld. The Model Summary for the regression revealed that all the other predictors of health performance at Ndejje health centre IV were held constant and the relationship was explained by accountability. A correlation coefficient (R), using the predictor; accountability, is .483 and the R2is equal to .233. The R square value gives the proportion of variance between the two variables (Amin, 2005). This implies that 23.3% (.233\*100%) variations in health performance at Ndejje health centre IV is explained by accountability while the remaining percentage of variations can be explained by other factors. The interpretation from this finding is that accountability contributes a reasonable proportion to health performance at Ndejje health centre IV.

The field survey findings showed that Ndejje health centre explains all action taken to stakeholders, that stakeholders enforce standards in the health facility, that it has checked corruption, that it has procedures for stakeholders to reprimand accountability and that there is value for money in the health investment.

The field results revealed that Ndejje health centre have PETS in place that minimize leakage and lead to appropriate use of funds, that Ndejje health centre publishes the receipt of funds in open for public to view, that it publishes the expenditure of funds in open for public to view and that the health centre calls for stakeholder meeting to present accountability.

## 5.3 Discussion of Findings

### 5.3.1 Citizen Participation and Performance of Ndejje Health Center

The study results showed that there is a positive and significant relationship between citizen participation and health performance at Ndejje health centre IV. The findings showed that if citizen participation improves there would be improvement in health performance. These findings are in agreement with those of Gaventa and Barrett (2010) who in evaluating 100 case studies that mapped the outcomes of citizen engagement, find over 30 cases in which significant impacts were made in service delivery including in the health and education sectors. Similarly, at Ndejje health centre, it is evident that Local Council (LCs) leaders and Health Unit Management Commitments (HUMCs) have various avenues for participating in health matters. This promotes involvement and monitoring and consequently good governance of health service provision is enlisted.

It was established from the field study results that Ndejje health centre involves local people in planning for health delivery. Involvement of local people is central in good governance. This provides information advantages in prioritizing health needs and investment. It is through this involvement that quantity and quality of health service is produced through governance. These findings are in agreement with Seekings (2013) and Bevir (2013) who found that system user involvement in planning such as participatory budgeting resulted in greater health improvements. This facilitates synergy in health promotion and the pool of ideas including those of the user system which have informational advantage.

# The field study findings showed that Ndejje health centre involves local people representative in setting health policies. Through governance parameters, people implement policies and programmes that reflect people’s real needs and preferences. These are usually premised on the contextual realities. These findings are in agreement with Fung (2006) who found that effectively structured participation in planning improves legitimacy and ownership of the service institution. Ownership promotes accessibility and productivity of the health system and consequently desired outputs and outcomes of health provision. This promotes utilisation of services thus productivity and feasibility of the health systems.

The field study findings indicated that Ndejje health centre involves local people representatives in budgeting for the health facility. Local people have the time and place knowledge with the flexibility to decide the provision of certain types of goods and services, particularly ones with large demand on local preference. These findings are in agreement with Dominguez (2011) who reports that consulting affected parties can produce very useful information about, for example, the functioning of little-understood public services that a government is thinking about reforming, or about practical difficulties that might arise from a proposed policy. Thus involvement in budget matters will help health planers at facility level to invest in areas that are health productive to the community.

The field study findings indicated that Ndejje health centre involves local people representatives in health staff recruitment. As mandated by decentralisation, the local councils demand and press to the district for more staffing when they realize that patient load is overwhelming. In some instances, local councils may second some health workers directly paid by local council funds. These findings are in agreement with Misra (2007) who found that community involvement in planning for health services in Andhra Pradesh, was consequential to health services improvement through community social accountability. However, findings disagree with those of Ergo et al, (2010) who found that planning at the decentralized level remains challenging for both DHOs and DCs in the hospital provision of services. However the latter’s findings were centered on the planning processes for central hospitals which are insufficiently linked to the planning processes of the districts they serve.

It was found out from the field results that Ndejje health centre involves local people representatives in human resource matters. Issues of absenteeism, late coming, abusive and rude language to patients can be addressed and condemned by local citizen leaders like the NGOs, local councils and HUMCs in appropriate fora. These findings are in agreement with Mansuri and Rao (2013) who in a review of a large number of projects found that participatory approaches that involve communities in at least some aspects of project design and implementation creates a closer connection between developments. Participation has therefore been seen as an instrument for building ownership and ensuring programme effectiveness. Community participation in the process of public service planning and delivery may also have the potential to improve service effectiveness and responsiveness.

# The field survey results revealed that Ndejje health centre involves local people representatives in crosschecking health supplies received. When the medical good and supplies arrive at the health centre, the HUMCs are informed and in time have the right to crosscheck the drug stock inventories. The HUMCs and local leaders are mandated to ensure that supplies are received and put into use appropriately. These findings are in agreement with those of Misra (2007) who in an analysis of the use of community monitoring by score cards in primary health care services in Andhra Pradesh, India found that the process resulted in increased user satisfaction levels and better understanding of the constraints providers face. Monitoring health supplies gives information whether they are adequate or lacking. Similarly, understanding of constraints in suppliers helps to set joint strategies to solve them. The field survey results revealed that Ndejje health centre involves local people representatives cross check health worker behaviors. In this way, they check misuse of human resources and ensure their productivity. These findings are in agreement with Savedoff (2008) who found that in a decentralized setting in Uganda, citizen representatives established to oversee most health care facilities showed that price data collected for various supplies found that hospitals that were supervised by active directorates paid less on average than hospitals that had directorates with less active citizen participation. In addition active directorates checked the negative attitude of health workers towards patients. This indicates that local citizen’s involvement check misappropriation and charging patients through under table payments.

#  The field survey results revealed that Ndejje health centre involves local people representatives in supervising health worker availability. In health units that are not supervise may be closed for most of the day. In addition, when few health workers turn up it leads to long queuing. This is consequential to patient dissatisfaction. These findings are in agreement with Bjorkman and Svensson (2009) who found that when local NGOs encouraged communities to engage with local health services, they were more likely to monitor providers. As a result, provider absenteeism declined and responsiveness increased in terms of shorter waiting times, greater efforts to respond to community needs. Usage of public health services also increased and was reflected in better health outcomes such as reduced child mortality.

# The field survey results revealed that Ndejje health centre involves local people representative in evaluating health service delivery. Community monitoring through various mechanisms of evaluation can improve the quality of services. These findings are in agreement with Dufils (2010) who found that in Madagascar, assessing services using the Local Governance Barometer (LGB) a process that involved local officials and communities improved health service provision. The resultant action plan had several positive impacts. The reports shows that effective channels of collaboration and communication were developed and complaint processes were improved. This puts the health system at check to provide the services that are intended.

# The field survey results revealed that Ndejje health centre involves local people representatives in supervising health facility projects. This minimises, late coming, absenteeism and negative attitudes towards health care seekers and ultimately shoddy work. These findings are in agreement with Bold et al (2010) who reports that the use of Citizen Report Cards as a move from satisfaction surveys to more objective indicators of the actual quality of services received is improving service delivery. The findings further agree with those of Dufflo (2013) who in a study in Mumbai, India, shows that a citizen group initiated the online Complaint Management System (OCMS) which streamlined all complaints on urban public services into an online database which could be used to compile data on time taken to address complaints compared to set norms. The study found that the system was successful in putting pressure on public officials to deal with complaints on time. The findings further agree with Sirker and Cosic (2007) who found that in Lok Satta, a citizen group in Andhra Pradesh, worked with municipal authorities to publicise citizen charters for forty common public services in one hundred municipalities in the state combined with efficient complaint mechanisms and found it to have efficacy gains on service delivery performance.

### 5.3.2 Transparency and Performance of Ndejje Health Centre

The study results showed that there is a positive and significant relationship between transparency and health performance at Ndejje health centre IV. The findings showed that if citizen participation improves there will be improvement in health performance. To this end, transparency is a significant factor of good governance in health care performance. These findings are in agreement with Vian et al. (2010) who realize that the common theme of transparency mechanisms as to make it possible for the stakeholders to understand an institution, identify possible malfeasance or incompetence, and adapt plans to its behaviour. In principle, it can also be an anti-corruption measure.

The field study results showed that Ndejje health centre communicates openly its performance to stakeholders. This indicates that conceptually Ndejje administration inform the public and other actors of both upcoming decisions and decisions that have been made and of the process and grounds on which decisions are being made. These findings are in agreement with Gahir (2015) who found that the many different channels for public sector entities to use to communicate with their stakeholders, including web-based information and social media have improve the performance of the public sector tremendously. When the institution has informs the public, it finds it difficult to deviate from the communicated plan.

It was found from the field study findings that Ndejje health centre allows stakeholders access to health facility information. Transparency is achieved through accessibility of policy documents related to health laws and bylaws, decisions, information campaigns and reports on analysis. These findings are in agreement with Green, (2014) who found that in Tanzania CSOs are assumed to play an important role in demanding access to information, providing services and advocating for rights for citizens. The findings further agree with Mapunda, (2012) who found that openness on information has improved services in Tanzania.On the contrary Green (2014) notes, that this agenda has been driven and shaped by donors and is not necessarily reflective of a sustainable and genuine local civic transparency process.

The field survey results indicated Ndejje health centre uses the available networks to avail user system health facility information. Transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor the services. These findings are in agreement with La Forgia, et al (2008) who while assessing hospital performance in Brazil found that when accountability reports are written and communicated in an open and understandable style appropriate to the intended audience, performance improves tremendously. The findings further agree with Kombani (2013) who reports that the Tanzanian government signed up the Open Government Partnership (OGP) which is a global initiative that aims at promoting transparency, fighting corruption and encouraging the use of new technologies to improve governance and this was found to have improved performance tremendously. This allows citizens to track and follow up on any complaints that may have been made.

# The study results revealed that Ndejje health centre user system are empowered to demand for health service information. This makes the health centre activities and the government indeed more open to its citizens in the interest of improving public service delivery and government responsiveness, combating corruption and building greater trust. These findings are in agreement with Sirker, and Cosic, (2007) who found that the marginalized were empowered to access service provision information in Asia and service improved greatly. Public scrutiny creates a demand for transparency and improves accountability, so its influence can help to build pressure for a more open, honest, and, ultimately, more effective public sector.

# The study findings revealed that Ndejje health centre reports health gains to stakeholders. The records are published for further planning. These findings are in agreement with Lindelow, (2006) who in a study on Tracking Public Money in the Health Sector in Mozambique found that where public sector entities demonstrate that they have delivered their stated commitments, requirements and priorities and have used public resources effectively to spur their performance, there was public satisfaction. Publish satisfaction is a major component in good governance and attracts utilisation of services. It further builds harmony and trust among service providers.

# The field study findings revealed that Ndejje health centre has appropriate avenues for reporting. There are various organisations for health provision that provide avenues for reporting. Such organisations include NGOs, coalitions for health and HMIS of the Ministry of Health so as to have a basis for planning. These findings are in agreement with Mushi (2011) who reports that in the context of Tanzania, the avenues for planning have facilitated advocacy for better governance at both national and local levels. This gives information that resources are being unitised for the right cause. This is similarly consequential to improved performance of the service being delivered.

# The findings revealed that Ndejje health centre reports all its obligations. These findings are in agreement with Lewis and Pettersson (2009) who found that entities that report payroll and in-kind and health worker performance demonstrate good practice to which they are applying the principles of good governance. The findings further agree with Rogall (2007) and Pathfinder (2013) who report that CSOs in Tanzania are often the preferred partner for donors and have improved service provision enormously because they report the health provisions appropriately. Ndejje heakth centre is a government health but still, it has an obligation to inform various stakeholders what it is doing. Reporting is very important for health gains and planning and in turn performance. It shows where gaps exist and definitely devise ways to fill such gaps.

# The findings revealed that Ndejje health centre reports accordingly. Health units as an obligation have to make available information on budget, recruitment and health provision. These findings are in agreement with Reinikka, and Svensson(2005) who found that availing information as a means to fighting corruption improve service delivery. The findings further agree with Renzio, et al ( 2006) who report that accessing budget information most especially by the Uganda Debt Network has improved budget performance and service delivery limiting the possible leakage.

### 5.3.3 Accountability and Performance of Ndejje Health Centre

The findings revealed positive correlation between accountability and health performance at Ndejje health centre IV. The findings showed that if citizen participation improves that there will be improvement in health performance. These findings are in agreement with Weale (2011) and Bovens(2010) who describe accountability as a pro-active process by which public officials inform about and justify their plans of action, their behavior and results, and are sanctioned accordingly. Accountability requires that public servants have clear responsibilities and are held answerable in exercising those responsibilities, and if they do not, face predetermined sanctions. Without sanctions there cannot be any real accountability. Sanction directs the service providers to be accountable and consequently health performance.

The findings revealed that Ndejje health centre explains all action taken to stakeholders. This is a form of accountability and good governance. This makes the health unit closer to the people and accountable for the services. These findings are in disagreement with those of Aiko et al. (2016) who found that in that in Tanzania citizens are not convinced it is their responsibility to hold LGAs accountable for service delivery. The findings further disagree with those of REPOA, (2014) report which found that citizens are also less likely to engage with their LGAs as there is a perception their concerns will not be heard or taken seriously.

The study findings revealed that Ndejje health center stakeholders enforce standards in the health facility. However, findings from observation showed that the compound was bushy and the latrines sanitation was not well maintained. The findings have similar analogs with those of Muro and Namusonge (2015) who found that in Tanzania even if community participation is seen as important and there is a conducive environment of accountability, community members indicated that lack of skills, had a negative impact on a citizen’s ability to participate and ensure that rules are enforced. This could be the reason why the level of cleanliness was observed lacking.

The findings revealed that Ndejje health centre have checked corruption. The involvement of local council leaders into the affairs of the health unit check corruption. Similarly the presence of HUMCs as representative of the people has been a means of checking corruption. These findings are in agreement with Savedoff (2008) who found that that good governance in health centres in Africa has minimized corruption due to overnight checking and demand for accountability.

The findings revealed that Ndejje health centre has procedures for stakeholders to reprimand accountability. The local council leaders and HUMCs have direct oversight on the health units. These findings Njunwa, (2011) who found that in Tanzania service providers can be held to enforce rules for service delivery through the 2000 Client Service Delivery Charter (CSDC). The CSDC is a social agreement between a public service provider and the user. It was developed as part of the public sector reform process that took place in Tanzania in the 1990s

The findings revealed that Ndejje health centre espouses value for money due to enforcing rules through good governance. These findings are in agreement with Hoffman (2006) found that that, in Tanzania, ‘individuals due to enforcing standards define political accountability of local governments primarily in terms of the amount of visible and tangible services they provide.

The findings revealed that Ndejje health center has PETS in place that minimize leakage and lead to appropriate use of funds. These findings are in agreement with Reinikka & Svensson (2006) who revealed that Surveys from PETS in Africa were found to tremendously minimize leakage and lead appropriate use of funds. The findings further agree with Lindelow (2006) who reports that more than two dozen PETS have been conducted in a range of low- and middle-income countries and the experiences demonstrate that the instrument is useful in improvement in service provision.

The findings revealed that Ndejje health centre publishes the receipt of funds in open for public to view. This makes the service providers take care in the utilization of funds since they are aware that the user system are in the know of the receipts. In essence it minimizes the waste and leakage. These findings are in agreement with Pande (2008) who reports that India pioneered the strategy of using public hearings (Jan Sunvais) to hold public officials accountable for local level implementation of programmes. Jan Sunvais operate by first gathering information about the budgets and expenditure in public programmes and presenting and verifying these in a public gathering in which all relevant stakeholders, public officials, elected leaders, private contractors and workers are present. These early public hearings had significant impact in exposing corruption in public programmes and in some instances even getting public officials to return the money that they had appropriated.

The findings revealed that Ndejje health centre publishes the expenditure of funds in open for public to view. This exposes where there is a mismatch in the expenditure. Because serice providers are aware they have an obligation, to publish the expenditure, they may not falsify the process. The findings are in agreement with Gauthier and Wane (2008) who found in a study in Chad that tracked resource flows and revealed considerable fund leakages. The findings helped determine which flows were more leakage prone and at what points in the health system leakages occurred. Resource flows included financial resources, medical materials, and main medications allocated to health care providers by the Ministry of Health. These consequently checked the leakage.

The findings showed that Ndejje health centre calls for stakeholder meeting to present accountability. The findings are in agreement with Duggal (2005) reports that in Parivartan, a grassroots organization in Delhi held public hearings on the implementation of the Public Distribution System (PDS) which is a large food subsidy programme intended for the poor. The depth of corruption exposed through the process led to improvements in the operation of PDS as well as institutionalization of a system of monthly ‘opening of the books’ for public scrutiny. The findings further agree with a study by Singh and Vutukuru (2010) of social audits in the state of Andhra Pradesh where the state took a lead in institutionalizing accountability and found that social audits have led to a statistically significant increase in services generated, as well as an increase in the exposure of corruption within the programme with a significant amount of programme funds being recovered.

**5.4 Conclusions**

On the basis of study findings, summary and the discussion, the following conclusions were made in line with the study objectives:

### 5.4.1 Citizen Participation and Performance of Ndejje Health Centre

Citizen participation is essential for implementing plans and strategies to stay on that path which promotes health performance improvement. Involvement of stakeholders improves planning as health policies, are tailored to what really matters for them in health service provision. This promotes ownership of the facility, utilization of services and consequently satisfaction.

**5.4.2 Transparency and the Performance of Ndejje Health Center**

In addition the study concludes that transparency fosters health performance through reporting which provides resources for strengthening systems, removes obstacles that interfere with high performance of health-care providers. Therefore an improvement on transparency will lead to an improvement on performance in terms of timely accomplishment of tasks at Ndejje Health centre.

### 5.4.3 Accountability and the Performance of Ndejje Health Center

Finally the study concludes that accountability is instrumental in good governance for health service performance. It provides the development of improvement plans/mechanisms for delivering quality services though enforcing rules, standards and sanctions which checks and demonstrates ability to manage financial resources for quality health performance improvements. Public expenditure tracking minimize leakage and lead to appropriate use of available resources.

## 5.5 Recommendations

On the basis of the above discussion and conclusions, the following recommendations were made in line with study objectives:

### 5.5.1 Citizen Participation and Performance of Ndejje Health Centre

The study recommends for MOH and district local government to strengthern capacity building among the citizens so as to spur knowledge for participation in health issues and be able to assess health systems.

### 5.5.2 Transparency and the Performance of Ndejje Health Center

The study also recommends to MOH, district planners and Ndejje health center to publish and issue governance indicators for health systems to facilitate on transparency for information reporting and access to information about budget management; human resources; institutional providers; informal payments and the entire health system performance.

### 5.5.3 Accountability and the Performance of Ndejje Health Center

The study recommends that the government of Uganda through the Ministry of Health and local governments should produce or author a good governance framework that facilitates health system governance principles to assess accountability. Certain broad principles should be proposed for both the national level and at the implementation level as an analytical framework to be used for an assessment of health system governance in matters of accountability. This can easily assist and make facility level stakeholders work quite affordable to enforce accountability.

## 5.6 Areas for Further Research

Basing on the fact that there are several variable that affect health service delivery, the study suggest further research on:

1. Clinical personnel involvement in leadership and service provision

2. The role of the local health insurance in improving the health disease incidence and burden.

## 5.7 Contribution to the Body of Knowledge

The study has inevitably establishing the objectives, answering the research questions and testing the research hypothesizes has made enormous contributions to the existing body of knowledge in the areas of community participation, transparency accountability and health service provision. The findings can further be analyzed and compared to other geographical settings.

## REFERENCES

*Advocates Coalition for Development and Environment*: (ACODE) Local Government Councils Scorecard Assessment 2012/2013. ACODE Policy Research Series, no. 70, 2015 Unlocking Potentials and Amplifying Voices

Agere, S. (2012). Promoting Good Governance. Commonwealth Secretariat. New York. Oxford University Press.

Aiko, R., Akinocho, H. and Lekorwe, M. (2016). ‘*Job Performance of MPs, Local Councillors: Are Representatives Serving Voters or Themselves*?’ Afrobarometer Dispatch 115, 15

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

Bevir, M. (2013). *A Theory of Governance*. Berkeley, CA: University of California Press.

Bevir, M. (2013*). Governance*: A very Short Introduction. Oxford, UK: Oxford University Press.

Bjorkman, M. and Svensson, J. (2009). “*Efficiency and Demand for Health Services*.” Washington, DC: World Bank. Mimeo.

Bovens, M. (2010). Two Concepts of Accountability: Accountability as a Virtue and as a Mechanism, *West European Politics*, 33: 946–67.

Cammack, D. (2011). Malawi's Political Settlement in Crisis’, *Background Paper 04, Africa Power and Politics Programme*, ODIr.

Cammack, D. (2012). ‘Peri-urban Governance and the Delivery of Public Goods in Malawi, 2009–11’, *Africa Power and Politics Research Report* 03, January.

Castro, M. (2013). [*Open Budgets Key to Open Governm*ent: Next Steps for OGP Countries](http://www.opengovpartnership.org/blog/michael-castro/2013/09/12/open-budgets-key-open-government-next-steps-ogp-countries#sthash.cFZvst8q.dpuf), retrieved 2 December 2016

Chowdhury, N. and Skarstedt, C.E. (2005). The Principle of Good Governance. Draft Working Paper” in, Recent Developments in International Law Related to Sustainable Development *of Governance and Public Administration 1(2) 44-56Journal*

De Fine Licht, J. (2014). Transparency Actually: How Transparency Affects Public Perceptions of Political Decision-Making, *European Political Science Review*, 6: 309–30

Dehn, J., Reinikka R. and Svensson, J. (2003). “Survey Tools for Assessing Performance in Service Delivery,” in François Bourguignon and Luiz A. Pereira da Silva, eds. *The Impact of Economic Policies on Poverty and Income Distribution: Evaluation Techniques and Tools*. New York, NY: Oxford University Press..

DFID (2011). *Malawi Gender and Social Exclusion Analysis*, Social Development Direct, Report . DFID

Dufils, J.M. (2010). Local Governance Barometer—Measuring Governance in Madagascar.” *In Social Accountability in Afric*a. Eds Mario Claasen and Carmen Alpin-Lardies. IDASA.

Duflo, E. (2013). Incentives Work: Getting Teachers to come to School. JPAL

Eaton, Tim V. and Michael, D. A. (2016). "Whistleblowing and Good Governance". *CPA Business Journal* 77, no. 6 : 66-71,

 Ergo, A., N. Shahi, T. Rashidi and Rozario, A. (2010).*Malawi Case Study: How Health System Strengthening Efforts Have Affected Maternal Health*, Health System Strengthening and Maternal Health, USAID, September.

Gauthier, B. (2006). *PETS –QSDS in Sub-Saharan Africa: A Stocktaking Study*, Washington, DC: The World Bank/HEC Montreal

Gaventa, J. and G. Barrett, G. (2010). *So What Difference Does it Make? Mapping the Outcomes of Citizen Engagemen*t. Draft IDS Working Paper.

Gaventa, J. and R. McGee,R. (2010). *Citizen Action and National Policy Reform. Making Change Happe*n. London: Zed Books.

Goddard, A. and Mzenzi, I. (2015).Accounting Practices in Tanzanian Local Government Authorities: Towards a grounded Theory of Manipulating Legitimacy’, in K. Jayasinghe, N.D. Nath and R. Othman (ed.) *Public sector accounting, accountability and auditing in emerging economies.* Research in Accounting in Emerging Economies, Volume 15. Bingley: Emerald Group Publishing, pp.109–42.

Green, M. (2014). *The Developmental State: Aid, Culture and Civil Society in Tanzania*. Oxford: James Currey.

Grindle, M. S. (2004). ["Good Enough Governance: Poverty Reduction and Reform in Developing Countries"](http://onlinelibrary.wiley.com/doi/10.1111/j.0952-1895.2004.00256.x/epdf). Governance: An International Journal of Policy, Administration, and Institutions.Vol. 17, No. 4: pp. 525–548.

Hufty, M. (2011*). "*Investigating Policy Processes: The Governance Analytical Framework *(GAF). In: Wiesmann, U., Hurni, H., et al. eds. Research for Sustainable Development: Foundations, Experiences, and Perspectives.". Bern: Geographica Bernensia: 403–424.*

IFAC (2013).*Good Governance in the Public Sector Consultation Draft for an International Framewor*k. International Federation of Accountants

Jaramogi, P. (2010) Staff Flee as Minister Makes Impromptu Visit to Wakiso Health Unit. *The New Vision* 27th September 2010

Kaufmann, D. and Aart, K. (2008). “Governance Indicators: Where Are We, Where Should We Be Going?” *The World Bank Research Observer*, 23(1):1-30.

Kaufmann, D., Aart, K. and Massimo, M. (2007). “*Governance Matters VI: Aggregate and Individual Governance Indicators for 1996–2006.*” World Bank Policy Research Working Paper 4280. Washington, DC: World Bank. July.

Kombani, C. (2013). Open Government Partnership in Tanzania: a paper presented in Rabat, Morocco; Available at : [*http://www.opengov.go*](http://www.opengov.go). Accessed 10 august 2017

La Forgia, G. M. and Bernard F. C. (eds). (2008). *Hospital Performance in Brazil: The Search for Excellence*. Washington, DC: World Bank.

Lewis, M. (2006). *Governance and Corruption in Public Health Care Systems*, CGD Working Paper 78, Washington, DC: Center for Global Development.

Lieberman, E.S., Posner, D.N. and Tsai, L.L. (2015) ‘Does Information Lead to More Active Citizenship? Evidence from an education intervention in rural Kenya’, *World Development* 60: 69–83.

Lindelow, M. (2006). “*Tracking Public Money in the Health Sector in Mozambique: Conceptual and Practical Challenges*,” East Asia Human Development Unit. Washington, DC: The World Bank.

Malengaa, C., (2017). “Social Accountability: An Introduction to the Concept and Emerging Practice” *in, Social Development Papers, Participation and Civic Engagement, World Bank, Paper* No.76, 2004

McNamara, B. (2006). Provider-specific report cards: a tool for health sector accountability in developing countries. *Health Policy and Planning.* Vol. 21, No. 2

Misra, V.( 2007).. ‘*Pilot Study 1, Andhra Pradesh, India: Improving Health Services through Community Scorecards*.’ Learning Notes, Social Accountability Series. Washington, DC: The World Bank.

Muganga. E. (2016). *Decentralized Planning and Social Service Delivery in Wakiso district. A Case of Health and Education Sector*. Un Published Extended Paper MA Public Administration and Planning MUK.

Muro, J.E. and Namusonge, G.S. (2015) ‘Governance Factors Affecting Community Participation in Public Development Projects in Meru district in Arusha in Tanzania’, *International Journal of Scientific and Technology Research*4(6): 106–10.

Mushi, A. (2011) ‘*Civil Society in the Era of Good Governance Dispensation: Non-governmental organizations (NGOs) and the Politics of Engaging Government in Tanzani*a’. PhD thesis, University of Birmingham.

Namara, S., W. Ssali, M. K. andAinembabazi., R. (2013). Local Government Councils’ Performance and Public Service Delivery in Uganda: Wakiso District Council Score-Card Report 2012/13. ACODE Public Service Delivery and Accountability Report Series No.18, 2013. Kampala.

Namara-Wamanga, S., Kikambuse, S. M. and Kansiime P (2013). *Local Government Councils’ Performance and Public Service Delivery in Uganda: Wakiso District Council Score-Card Report 2011/12*. ACODE Public Service Delivery and Accountability Report Series No.3, 2013. Kampala

Newton, P. N., Sue, J. Lee, C., Facundo, G. Fernández, M. and Shunmay, Y., et al. (2009) “Guidelines for Field Surveys of the Quality of Medicines: A Proposal.” *Journal of PLoS Medicine* 6(3):

Nguyen, T. and Lassibille, G. (2008). “Improving Management in Education: Evidence from a Randomized Experiment in Madagascar.” *Draft paper from JPAL website accessed 3. July 2017.*

Njunwa, M. H. (2011). Achieving the Millennium Development Goals through innovative public service delivery: A critical assessment of implementing client service charters in Tanzania. JOAAG, 6(1),

Ojera- Abusu, J. (2017). Absenteeism and Extortion Rampant in Wakiso health Centres. A report by the Health Monitoring Unit on the state of Health Services in Wakiso Dstrict. Uganda Health Monitoring Unit

Olken, B. (2007). Measuring Corruption: Evidence from a Field Experiment in Indonesia.” *Journal of Political Economy* 2 (3)

Olsen, C. and Marie D. M. (2004).*Cross-Sectional Study Design and Data Analysis*: Walden University Chicago, Illinois

Pande, S. (2008). “*The Right to Information and Societal Accountabilty: The Case of the Delhi PDS Campaign*,” IDS Bulletin. Vol, 38 No. 6.

Pathfinder (2013) ‘Use of citizen report card to assess local family planning needs in Tanzania’, [*http://www.pathfinder.org/publications-tools*](http://www.pathfinder.org/publications-tools) *acccessed 10 july 201*7

PATHS (2008).Celebrating Success*. PATHS in Nigeria (2002-2008). Final Programme Report*, Partnership for Transforming Health Systems. http://www.lath.com/Our-Projects/12

Ravindra, A.. ( 2004). ‘*An Assessment of the Impact of Bangalore Citizen Report Cards on the Performance of Public Agencies’*, Evaluation Capacity Development Working Paper no.12, Operations Evaluation Department, World Bank, Washington

Reinikka, R. and Svensson, J. (2006), “Using Micro-Surveys to Measure and Explain Corruption,” *World Development,* 34(2): 359–370. February.

Reinikka, R. and Svensson, J. (2006). “Using Micro-Surveys to Measure and Explain Corruption,” World Development*,* 34(2): 359–370. .

Reinikka, R. and Svensson. J. (2005). Fighting Corruption to Improve Schooling: Evidence from a Newspaper Campaign in Uganda. *Journal of the European Economic Association*. Vol. 3, No. 2-3.

Renzio, P. de, Azeem, V. and Ramkumar, V. (2006). *Budget Monitoring as an Advocacy Tool*: Uganda Debt Network,” Case study Prepared for the Research Project: Lessons from Civil Society Budget Analysis and Advocacy Initiatives.

Rocha M. A. (2011) [*"Analysing the Relationship Between Democracy and Development*"](http://www.odi.org.uk/node/8129), Overseas Development Institute

Savedoff, W. *D.* (2011*).Governance in the Health Sector A Strategy for Measuring Determinants and Performance The* World Bank Human Development Network Office of the Chief Economist. Policy Research Working Paper 5655

Savedoff, W, D. Gottret, P, eds. (2008). *Governing Mandatory Health Insurance: Learning from Experience.* Washington, DC: World Bank.

Savedoff, W.D. (2008). “*Public Expenditure Tracing Surveys: Planning,Implementation and Uses*”, Mimeo, Washington, DC: Social Insight and World Bank.

Singh, R. and Vutukuru, V.(2010). *Enhancing Accountability in Public Service Delivery through Social Audits: A Case Study of Andhra Pradesh*’, Accountability Initiative, Centre for Policy Research, New Delhi

Sirker, K. and Cosic, S. (2007).*Empowering the Marginalized: Case Studies of Social Accountability Initiatives in Asia*. Washing DC: The World Bank.

.

Stewart, E. (2013) What is the point of citizen participation in health care? *Journal of Health Services Research & Policy,*18: 124–6.

Sundet, G. (2004). *Public Expenditure and Service Delivery Monitoring in Tanzania: Some International Best Practices and a Discussion of Present and Planned Tanzanian Initiatives*.” Hakielimu. Working Paper No. 7

[*The IMF's Approach to Promoting Good Governance and Combating Corruption — A Guide"*](http://www.imf.org/external/np/gov/guide/eng/index.htm). International Monetary Fund.( 2005)*. Retrieved November 2, 2016*.

Tritter, J. Q., Koivusalo, M. and Ollila, E. (2010). Globalisation, Markets and Healthcare Policy: Redrawing the Patient as Consumer. London: Routledge.

Uganda DISH.( 2003). Uganda Delivery of Improved Services for Health (DISH) Project, Uganda/USA. *Website: [http://www.ugandadish.org], accessed 3.July 2017*.

[UNESCAP](https://en.wikipedia.org/wiki/UNESCAP). (2009).[*"What is Good Governance"*](http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp)*.*. Accessed Dec 10, 2016.

United Nations. (2007). *Auditing for Social Change: A Strategy for Citizen Engagement in the Public Sector Accountability.* Department of Economic and Social Affairs, Division for Public Administration and Development Management. New York: United Nations.

Urbinati, N. and Warren, M. M. E. (2008) The concept of Representation in Contemporary Democratic Theory, *Annual Review of Political Science*, 11: 387–412.

Weale, A. (2011) New Modes of Governance, Political Accountability and Public Reason, *Government and Opposition,* 46: 58–80.

Welch, G. and Nuru, Z.( eds). (2006). “Governance for the Future: Democracy and Development in the Least Developed Countries.” UN Development Program and UN Office of the High Representative for the Least Developed, Landlocked Developing Countries, and the Small Island Developing States. [*http://www.un.org/special-rep/ohrlls/ldc/Governancereport.pdf*](http://www.un.org/special-rep/ohrlls/ldc/Governancereport.pdf)

World Bank (2007), *World Development Report 2007: Making Services Work for Poor People*. Washington, DC: World Bank.

[*World Governance Index 2009 Report"*](http://www.world-governance.org/spip.php?article469)*. World Governance. Retrieved 3 February 2013.*

World Health Organization (2006). “Measuring Transparency to Improve Good Governance in the Public Pharmaceutical Sector: Draft Assessment Instrument,” Working draft for field testing and revision. Geneva: World Health Organization. January.

World Health Organization (2008). “*Toolkit on monitoring health systems strengthening: Health Systems Governance*,” Geneva: World Health Organization.

World Health Organization (2009). “General information on counterfeit medicines.” Geneva: Switzerland. Retrieved from [*http://www.who.*12.9.2017](http://www.who.12.9.2017)

Bai, G. (2013*). How Do Board Size and Occupational Background of Directors Influence Social Performance in For-profit and Non-profit Organizations? Evidence from California Hospitals*. J Bus Ethics;118:171–187.

De Andrade, C.L. (2014). *The effect of physician board membership on uncompensated care provision*. Appl Econ ;46:2290–2300.

Gruber, J. and Rodriguez, D. (2007). *How much uncompensated care do doctors provide*? J Health Econ ;26:1151–1169

Brickley JA, Van Horn RL, Wedig GJ. (2010). Board composition and nonprofit conduct: Evidence from hospitals. J Econ Behav Organ;76:196–208

Glaeser, E.L. (2007). The Governance of Not-for-Profit Organizations. Chicago: University of Chicago Press

## APPENDICES

## Appendix I: Questionnaire for Political Leaders Health Worker Staff on good Governance and Performance of Ndejje Health Centre

Dear respondent,

 You have been selected to participate in the study that seeks your response good governance and performance of Ndejje health centre

Please respond to all questions as honestly as possible. All information obtained is confidential and for research purposes. Feel free and ask where you do not understand. The information will be treated in aggregate and your name or that of your department will not appear anywhere in the report. Can I proceed with the exercise?

**SECTION A PERSONAL DATA.**

Use a tick (√) where appropriate

1. Sex: Male Female

2. Working experience 0-5 yrs 5-10 10-15Yrs 15-

3. Qualification: Certificate Diploma Bachelors degree Masters Others-

4. Age –21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60

In the next part, kindly rate the statements below by ticking the appropriate box to show your level of agreement or disagreement of the statement. (5 **SA-Strongly Agree, 4 -AAgree, 3NS-Not sure, 2Disagree, 1 SD-Strongly Disagree)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Items**  | **SA** | **A** | **NS** | **D** | **SD** |
| **Section B: 5.0 Citizen Participation** |
| **5.1**  Citizen involvement in health planning |  |  |  |  |  |
| 5.1.1. Ndejje health centre involves local people in planning for health delivery  |  |  |  |  |  |
| 5.1.2 Ndejje health centre involves local people representative in setting health policies  |  |  |  |  |  |
| 5.1. Ndejje health centre involves local people representatives in budgeting for health facility  |  |  |  |  |  |
| 5.1.4. Ndejje health centre involves local people representatives health staff recruitment  |  |  |  |  |  |
| 5.1.5. Ndejje health centre involves local people representatives in human resource matters  |  |  |  |  |  |
| **6.2 Citizen Monitoring** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 6.21. Ndejje health centre involves local people representatives in cross checking health supplies received |  |  |  |  |  |
| 6.2.2 Ndejje health centre involves local people representatives cross check health worker behaviors  |  |  |  |  |  |
| 6.2.3 Ndejje health centre involves local people representatives in supervising health worker availability  |  |  |  |  |  |
| 6.2.4 Ndejje health involves local people representative in evaluating health service delivery |  |  |  |  |  |
| 6.2.5. Ndejje health centre involves local people representatives in supervising health facility projects |  |  |  |  |  |
| **Section C :6.0 Transparency**  |
| **6.1** Accessibility to health information |  |  |  |  |  |
| 61.1. Ndejje health centre communicates openly performance to stakeholders  |  |  |  |  |  |
| 61.2 Ndejje health centre allows stakeholders access to health facility information  |  |  |  |  |  |
| 6.1.3 Ndejje health centre uses the available networks to avail user system health facility information  |  |  |  |  |  |
| 6.1.4. Ndejje health centre user system are empowered to demand for health service information  |  |  |  |  |  |
| **6.2 Reporting of Health Hnformation** |  |  |  |  |  |
| 6.2.1 Ndejje health centre reports health gains to stakeholders |  |  |  |  |  |
| 6.2.2 Ndejje health centre reports has appropriate avenues for reporting  |  |  |  |  |  |
| 6.2.3 Ndejje health centre reports all its obligations  |  |  |  |  |  |
| 6.2.4 Ndejje health centre reports accordingly  |  |  |  |  |  |
| **70. Accountability**  |  |  |  |  |  |
| **7.1 Enforcing Rules** |  |  |  |  |  |
|  7.1.1 Ndejje health centre explains all action taken to stakeholders |  |  |  |  |  |
| 7.1. Ndejje health center stakeholders enforce standards in the health facility |  |  |  |  |  |
| 7.1.3 Ndejje health centre have checked corruption  |  |  |  |  |  |
| 7.1.4. Ndejje health centre has precedures for stakeholders to reprimand accountability |  |  |  |  |  |
| 7.1.5 Ndejje health centre there is value for money  |  |  |  |  |  |
| **7.2 Public Expenditure Tracking** |  |  |  |  |  |
| 7.2. 1 Ndejje health centre PETS in place that minimizes leakage and lead appropriate use of funds. |  |  |  |  |  |
| 7.2.2. Ndejje health centre publishes the receipt of funds in open for public to view |  |  |  |  |  |
| 7.2.3 Ndejje health centre publishes the expenditure t of funds in open for public to view |  |  |  |  |  |
| 7.2.4 Ndejje health centre calls for stakeholder meeting to present accountability  |  |  |  |  |  |
| **8.0 Performance of Ndejje Health Centre**  |  |  |  |  |  |
| 8.1 Health Worker Performance  |  |  |  |  |  |
| 8.1.1 Ndejje health centre has adequate staff  |  |  |  |  |  |
| 8.1.2. There is availability of staff at Ndejje health centre  |  |  |  |  |  |
| 8.1.3 Ndejje health centre staff have positive attitude towards patients |  |  |  |  |  |
| 8.1.4. Ndejje health staff are committed to health provision  |  |  |  |  |  |
| **8.2 Health budget performance**  |  |  |  |  |  |
| 8.2.1 The health Funds reach health facility  |  |  |  |  |  |
| 8.2.2 There is general Cleanliness  |  |  |  |  |  |
| 8.2.3 Health infrastructure is well renovated  |  |  |  |  |  |
| **8.3 Facility Outputs** |  |  |  |  |  |
| 8.3.1 The health facility utilization is productive  |  |  |  |  |  |
| 8.3.2. There is client satisfaction  |  |  |  |  |  |

**THANK YOU VERY MUCH**