CITIZEN PARTICIPATION AND PERFORMANCE OF HEALTH CENTRES IN WAKISO DISTRICT, UGANDA: A CASE OF SELECTED HEALTH CENTRES IN NANSANA MUNICIPALITY

BY

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DECLARATION

I, Albert Collins Kyeyune, declare that this study is my original work and that it has never been submitted to any other institution for any other academic award before. Where the works of others was used, it has been duly acknowledged.

Albert Collins Kyeyune

Signature…………………………………………………..

Date………………………………………………………..

APPROVAL

This study was conducted under my supervision and the dissertation has been submitted for examination with my approval as the candidate's supervisor.

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DEDICATION

This study is dedicated to my father Dr. Richard Kulabako Nyombi, my dear wife, Rachael Namayanja Kyeyune and my sons, Eitan Christian Kulabako and Elisha Kyeyune.

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This work involved support from a number of people without whom completion may not have been possible. This is my precious moment to acknowledge all of them. First and foremost I wish to acknowledge my supervisors Dr. Michael Kiwanuka and Mr. Felix Andama A'diburu for their tireless support and guidance extended to me in preparing a proposal, conducting the study and compiling this report.

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LIST OF ACRONYMS

MC	Municipal Council
HC	Health Centre
VHW	Village Health Workers
CSO	Civil Society organization
NGO	Non-governmental Organization
MoH	Ministry of Health

ABSTRACT

The study examined the effect of citizen participation on the performance of health centres in Wakiso district in Uganda taking the case of selected HCs in Nansana Municipality. This study was motivated by concerns about poor accountability and misappropriation of public resources like medicines that was perhaps occasioned by inadequate participation of citizens in healthcare activities. This study investigated the following objectives: to examine the effect of participatory planning on the performance of Nansolo, Nabweru and Nakuule HCs; to determine the effect of participatory implementation on the performance of Nansolo, Nabweru and Nakuule HCs; and to examine the effect of participatory monitoring and evaluation (M & E) on the performance of Nansolo, Nabweru and Nakuule HCs in Nansana MC, Wakiso district. The study adopted the case study research design with survey strategy covering a sample of 112 respondents using documentary review, interview, questionnaire survey and focus group discussion methods. The study found a very strong and positive correlation between participatory planning and performance of Health Centres (HC) and participatory implementation and performance of Health Centres (HC) while correlations between participatory monitoring and evaluation was found to be moderately strong. Regression results indicated statistically significant relationships between the variables. The study concluded that in order to achieve enhanced HC performance, citizens should meaningfully participate in the entire healthcare planning process, implementation and M & E of healthcare activities. The study recommended that the Ministry of Health (MoH), Civil Society Organizations (CSO) and Non-governmental Organizations (NGO) should develop the capacity of HC staff in participatory approaches to healthcare service delivery; the Municipal Public Health Officer, CSOs and NGOs should increase citizen awareness and sensitize them on participation in healthcare activities, conduct M & E, produce scorecards, arrange public hearings and barrazas not only to provide citizens with vital information but also to receive their views and reactions.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

At a point when the general criticisms with the public service delivery approaches are high, citizen participation has been acknowledged to have the potential for fostering good governance and increasing democratic control of public services in many developing countries in the world (Kugonza & Mukobi, 2015; Marzuki, 2015). Citizen participation is deemed vital towards the democratization of social-economic values, better planning and fulfillment of citizen demands. To this end therefore, increased democratic control could enhance the performance of public service delivery institutions like Health Centres (HCs) in Uganda. In reality, evidence of the impact of citizen participation on the performance of healthcare facilities is mixed (Yang & Pandey, 2011). Although there are a few studies relating to the direct influence of citizen participation on the performance of healthcare facilities in developing countries, there seems to be no systematic study on performance of HCs in Uganda and Wakiso district in particular (Devas & Grant, 2003). This study therefore examined the effects of citizen participation on the performance of Health Centres in Nansana Municipal Council (MC), Wakiso district.

Citizen participation in this study was taken as the independent variable while performance of HCs was the dependent variable. This chapter covers the background to the study, problem statement, general and specific objectives of the study, research questions and hypotheses. This chapter also presents the significance and justification of the study, scope of the study, conceptual framework, and operational definitions of concepts employed in the study.

1.2 Background to the Study

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

1.2.1 Historical Background

Although the historical evolution of citizen participation, as a concept, dates back to the ancient Greece in the 6th Century, the tradition of citizen participation can be traced from the US much earlier than the revolutionary war with emphasis centered on government by the people (Rhefeld, 2005). Around that time, although citizen participation in decision making at community level was restrained by economic status, gender, race and education status, it was generally not in dispute that the ultimate authority in decision making rested with the people (Strange, 1972). This implied that the principle and objectives of community participation and government control were well known and appreciated. Indeed, the translation of that principle into institutional forms, policies and practices happed in many ways. In the same pursuit, the establishment of the decentralized federal system of governance for example, was intended to ensure that citizens as individuals and representatives are given an opportunity in their governance. Overtime, other institutional changes including extension of suffrage to the property-less, Negroes, women, immigrants and the poor are evidences of the significance attached to citizen participation (Box & Richard, 1998).

The notion of citizen participation was later developed and adopted by Colonial New England and towards 1960s; governmental procedures were developed to accommodate "external" participation. Citizen involvement was premised on President Lyndon Johnson's “Great Society programs” that were later rolled out to empower citizens. Citizens were as a result for the first time, afforded an opportunity to participate in decision-making on matters

that affected them. This notion has become the foundation upon which citizen participation in public service delivery is premised (Cogan & Sharpe, 1986).

In the African context, historically decision making has ordinarily been expert-oriented, mostly obscure procedures applied by government bodies to rationalize and defend regulatory decisions made outside the public arena. At that time, the significance of public involvement was not explicitly appreciated and recognized within the paradigm. Later on, this trend of making informed decisions was transformed as it was deemed that public service delivery systems that were detached from the people were more controversial, costly and complicated to solve than originally perceived. It has become imperative that decisions affecting publics should not only be based on the best existing scientific information and understanding, but must also put into consideration the interests, aspirations, beliefs and values of interested and parties affected, including business people, community members and civil society (Samah & Rref, 2011). Meaningful citizen consultation, voice and engagement have increasingly become an inherent component of governance because they promote citizen buy-in, tap into the unique nature of citizen knowledge, and consequently promote democratic governance. In the context of Uganda, it is government policy that citizens as groups or individuals should be involved in decision making on matters that affect them to pick their voices and preferences. The decentralization reforms in the country are intended to support the same (Devas & Grant, 2003).

1.2.2 Theoretical Background

Scholars have increasingly used theories to explain phenomena that will likewise be adopted in this study. This study was underpinned by the Theories of Representative Democracy propounded by Locke in the 1680s and the Elite (Traditional) Democracy Theory by Dahl

(1989). The theories hypothesize that (all) people whom a particular decision affects should participate in the making of such decisions so that their interests can be embraced (Samah & Aref, 2011). Citizen participation can therefore be construed to be direct in the classical democratic sense or indirect - through (elected) representatives to voice citizens' views in a pluralist-republican democratic model as suggested by Kweit and Kweit (1986). The theory posits that policies in democratic processes should be evaluated against accessibility of the (policy) process and responsiveness of the policies to those it affects rather than on their mere efficiency or rationality to (local) governments (LG). This theory fitted the instant study to the magnitude that citizen participation would lead to the outcome that citizens' desire in terms of efficiency and availability of public services.

The Elite (Traditional) Democracy Theory on the other hand describes citizen participation as scramble for authority among the narrow elites. In this context, the responsibility of average citizens is restricted at involvement in periodical voting. It is also to ensure that elected leaders (governing elites) can be overthrown from power when the need arose; otherwise, citizens are regarded to be observers of the political game. The Traditional (Pluralist) Democracy Theory postulates that policy-formulation in liberal democracies is expected to be largely influenced by opinion leaders and groups. This could more astutely mirror the benefits of a community into the inter-play of the different beneficiary groups and organizations as observed by Dahl, (1989). Additionally, Civil Society Organizations could represent citizens by advocating for their interests through participation in public hearing sessions.

Politics is thus substantially a hassling process between participants of different social interests. Different categories of expertise can be mobilized as vital resources in such a meaningful bargain. A combination of the Pluralist and Elite Democratic Theories together

forms the concrete foundation of most realistic work in comparative politics. The two variants together form the Theories of Representative Democracy. Despite some criticisms by some scholars, the theories, are, nonetheless, still useful in explaining citizen participation and performance of HCs which was the main thrust of this study.

1.2.3 Conceptual Background

The main concepts employed in this study were citizen participation and performance of HCs. There are as many definitions of citizen participation as its commentators making a uniform definition not possible. However, one of the more plausible definitions as postulated by Cogan and Sharpe (1986) refers to Citizen Participation as a system which affords private individuals a chance to command public decisions. This description implies that private individuals have a direct voice in public decisions that affect them. Citizen participation could help to better foster citizens' needs, improve local planning, enhance rational decision-making and ease the implementation of decisions (Roberts, 2008; United Nations (UN), 2008; Neshkova & Guo, (2011); Lu & Xue, (2011); Yang & Pandey, (2011). It could also produce equity-based decision-making and inclusive development as postulated by Mohanty, (2010). In supplementation, Venugopal and Yilmaz, (2009) also observed that this could help to deliver better services and produce "outcomes that favor the poor and disadvantaged" UN, (2008,), p. 23. This study will conceive citizen participation as participatory planning, implementation and M&E.

On the other hand, Performance of organizations like HCs have been defined by the World Health Organization (WHO, 2006) as an organization that operate in ways that are responsive, just, fair, equitable and efficient to realize the best health outcomes possible, given the available resources and situation at hand. In this study, performance of HCs was

conceived as availability of healthcare, responsiveness to citizen's needs and fairness and equity of services delivered.

1.2.4 Contextual Background

In the Ugandan context, each local administrative unit has been provided with HCs, namely: HC IV at the Municipality, HC III at Division and HC II at Parish levels. The National Objectives as stipulated in the 1995 Constitution of the Republic of Uganda, as amended, calls for the observance of democratic principles that empower and encourage the active involvement of all citizens at all stages in their own governance. Pursuant to this objective, the Local Government Act (1997) as amended, has devolved a wide range of functions to LGs, together with greatly increased resources where elected leaders (Local Councils (LC) at various stages are mandated to formulate policies, approve budgets and provide political oversight (Uganda, 1997; Ministry of local Government (MoLG), 2012). Funding to LGs have been in terms of conditional grants to finance basic social services and unconditional component that local priorities need to focus (Sect. 77 Local Governments Act, 1997) (as amended) while substantial financial resources have been directed to the health sector (Ministry of Health (MoH), 2016). The LG guidelines provide that LGs, should evaluate citizens' needs, priorities and decisions to inform services that they provide (MoLG, 2013). This raises concerns about the level of performance of HCs in terms of availability, responsiveness and fairness of health care provision and the extent of citizen involvement in public service provision that the study sought to examine. This is against the backdrop of misappropriation of medicines and poor accountability by public officials which signals poor oversight roles by citizens and their political leaders.

1.3 Statement of the Problem

Citizen participation efforts reported in Uganda's HCs include political oversight by elected leaders, direct participation by individual citizens and by CSOs/ NGOs on behalf of citizens (Kyohairwe, 2009; 2013; MFPED, 2017). Despite these efforts, its impacts on the overall performance of the HCs has been meagre as local needs are poorly prioritized, competence of elected leaders are inadequate and accountability by public officials have been low as reported in Wakiso district. Additionally, drugs have been misappropriated by health workers in the district (Advocates Coalition for Development and Environment (ACFODE), 2015; Omollo, 2016) depriving patients of desired health care opportunities. The seeming remoteness of citizens from effective participation in planning, implementation and M & E of health care activities could have constrained the performance of HCs in Nansana MC as suggested by Michels (2012).

When issues related to HC performance like availability, responsiveness and equity of healthcare services are not addressed, then achievement of a country's development goals could be constrained (Ringold, Holla, Koziol & Srinivasan, 2012). Uganda risks failing to achieve the United Nations Sustainable Development Goal (SDG) for Health and specifically, Goal 3 of the National Development Plan, to "*Ensure healthy lives and promote well-being for all at all ages"* (Uganda National Development Plan II, 2015). It could also lead to increased incidence of deaths of the poorer sections of the population that cannot afford private healthcare costs and reduce productivity in the economy due to illnesses. This has motivated this study that examined the effect of citizen participation on the performance HCs in Nansana MC, Wakiso district in Uganda.

1.4 General Objective of the Study

The general objective of this study was to examine the effect of citizen participation on the performance of HCs in Nansana MC, Wakiso district.

1.5 Specific Objectives of the Study

The specific objectives of this study were:

1. To examine the effect of participatory planning on the performance of Nansolo, Nabweru and Nakuule HCs in Nansana MC.
2. To determine the effect of participatory implementation on the performance of Nansolo, Nabweru and Nakuule HCs in Nansana MC.
3. Examine the effect of participatory monitoring and evaluation on the performance of Nansolo, Nabweru and Nakuule HCs in Nansana MC.

1.6 Research Questions

1. What is the effect of participatory planning on the performance of Nansolo, Nabweru and Nakuule HCs?
2. How does participatory implementation affect the performance of Nansolo, Nabweru and Nakuule HCs?
3. What is the effect of participatory M & E on the performance of Nansolo, Nabweru, Nakuule HCs?

1.7 Research Hypotheses

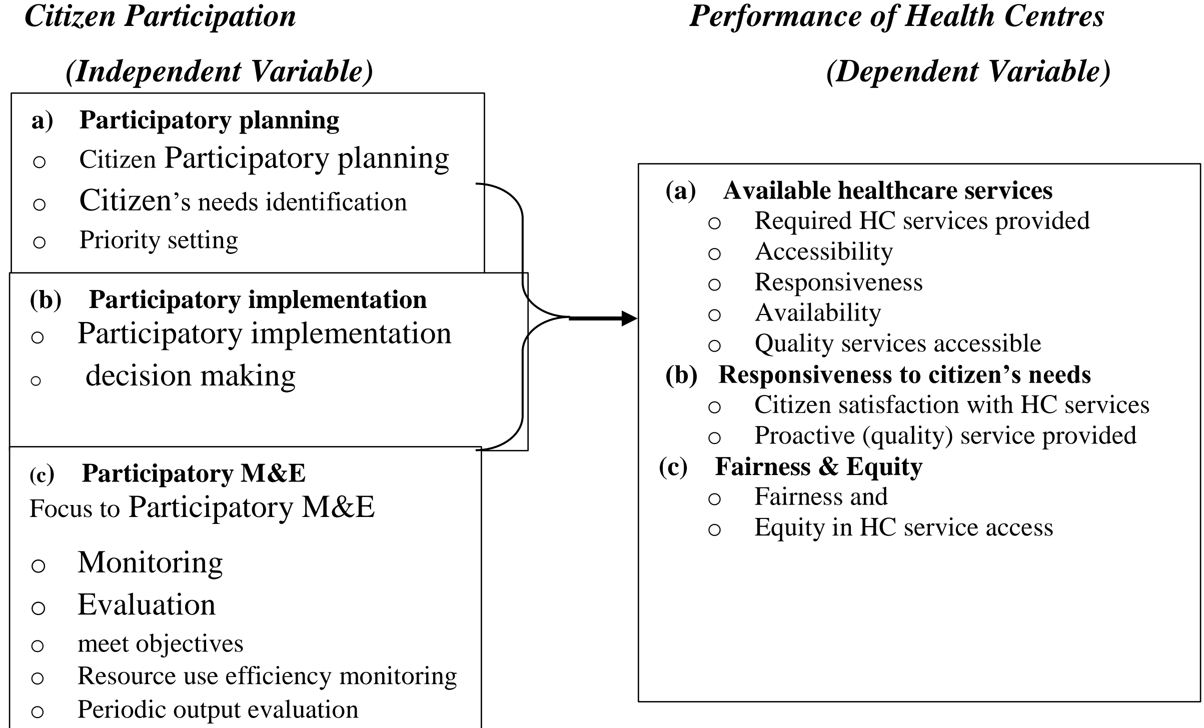
This research was guided by the research hypotheses below:

1. Participatory planning has a significant positive effect on the performance of HCs in Uganda.

2. Participatory implementation has a significant positive effect on performance of HCs in Uganda.
3. Participatory M & E have a significant positive effect on the performance of HCs in Uganda.

1.8 Conceptual Framework

The conceptual framework showing the relationship between the citizen participation and performance of HCs is depicted in Figure 1.



Source: Adopted and modified from WHO (2006); Lu & Xue (2011); Yang & Pandey (2011).

Figure 1.1: Citizen Participation and Performance of Health Centres

This study conceived the independent variable to be Citizen Participation: Participatory planning (citizens needs identification and setting priorities); Participatory implementation (rational decision making); and participatory M&E (focus to meet objectives, monitoring efficiency of resource utilization and periodic output evaluation). The independent variable

was posited to influence the dependent variable, Performance of HC: Availability (required healthcare services provided, and ease of access of healthcare services); Responsiveness (Citizen Satisfaction with services and proactive (quality) services provided; and fairness and equity in healthcare service access).

1.9 Significance of the Study

The findings of this study may be significant in several folds. They could assist policy makers in Local Governments of Uganda to formulate or influence policy decision from informed view point with regard to community participation and performance of HCs in Uganda.

The study findings may also be invaluable to Nansana MC as it is anticipated to provide valuable information that could be utilized to re-direct community participation towards performance of HCs.

The study findings could also contribute to the academia by extending the body of knowledge on community participation and performance of HCs in developing countries like Uganda.

1.10 Justification of the Study

This study was justified at this time that more resources have been committed to LGs for implementation of public activities at LG level to improve local service delivery while new HCs have also been constructed to meet the increased needs of the local populace (MoH, 2016) which raises concerns about the extent to which citizenry priorities and input are put into consideration. It is also justifiable as it would evaluate the extent to which public services are prioritized to mitigate ineffective delivery of public services to meet citizen's needs. The voices of the marginalized are often not heard, this study will unveil the extent to which public services are responsive to the needs of various sections of society. Methodologically, this study diverges from previous ones that used econometric binomial

logit model to investigate citizen participation and local government effectiveness like those of Morales (n.d). This study adopted the ordinary least squares estimation procedures of regression analysis and supplemented by individual perceptions and views that were collected by use of in-depth interviews and focus group discussions.

1.11 Scope of the Study

This section was limited in terms of location (geography), content and time scope. Presented in the sub-sections are details on the scope of the study.

1.11.1 Geographical Scope

This research was limited to the geographical boundaries of Nansana MC in Wakiso district in Central Uganda. The health centres observed were Nansolo HC II, Nabweru HC III and Nakuule HC II in Nabweru Division. Nansana M.C was selected for this study because other than being one of the most recent municipalities created, the densely populated urban authority mirrors all the health challenges facing Local Governments in Uganda in terms of healthcare performance. For example statistics in Nabweru HC III alone estimates a patient coverage for up to 187,000 people.

1.11.2 Content Scope

The subject content was limited to citizen participation and performance of Health Centres in Nansana MC in Wakiso District. Citizen participation was construed to include participatory planning, implementation and monitoring and evaluation. The performance of HCs was measured by availability of healthcare services, responsiveness to citizen's healthcare needs and equity and fairness of healthcare service access by citizens. These indicators are

anticipated to provide sufficient data for evaluation of the performance of health facilities as suggested by WHO (2006) and UN (2008).

1.11.3 Time Scope

This study was limited to the period from 2011 to June 2018. This is because it is the period when numerous pledges and commitments were made to strengthen decentralized service delivery during presidential election campaigns of 2011 as a reference point to stimulate respondent recall (memory) through the national presidential elections of February 2016 following the Presidential elections and policy framework after the run- up for the February 2016 national (presidential) polls up to December 2017. This approximately eight-year period is anticipated to provide the requisite data for analyses to meet the objectives of this study.

1.12 Operational Definition of Key Terms and Concepts

Citizen participation: Active involvement in public decision making and M&E of health service delivery in public HCs. Mechanisms for hearing local voices, engaging local energies, and alignment of budgets with local needs, strengthened social capital, deepening access of the poor to healthcare services, civic empowerment, maximization of choice and opportunities, and active measures to counteract discrimination against vulnerable groups.

Performance of HC: Performance of HC refers to provision of healthcare in the HC in the way that is "responsive, fair and efficient to achieve the best health outcomes possible, given the available resources and circumstances" (WHO, 2006).

Participatory planning: Is a set of processes through which diverse groups and interests engage together in reaching for a consensus on a plan and its implementation. It is a process aimed at defining, proposing and having enforced a management plan on issues of common interest where no party should lose out completely.

Participatory Implementation: Is a process of engaging stakeholders including the local people in application of planned activities to deliver services.

Participatory monitoring and evaluation: Is a process where primary stakeholders – those who are affected by the intervention being examined – are active participants, take the lead in tracking and making sense of progress towards achievement of self-selected or jointly agreed results at the local level, and drawing actionable conclusions. The effectiveness (and sustainability) of such a process requires that it be embedded in a strong commitment towards corrective action by communities, project management and other stakeholders in a position to act.

Available healthcare services: Healthcare services that citizens (patients) often required are provided at HCs. The services should also be accessible in terms of distances from place of aboard and HCs, costs if any, irrespective of social and economic status.

Responsiveness to citizen's needs: Citizens show satisfaction with healthcare services provided at HCs. Quality healthcare services are provided through a systematic process of consistently reviewing citizen's expectations and the quality of care they receive.

Fairness and Equity: The perception that healthcare is received by all those that are in need. They are received by all categories of patients in terms of age, gender, ethnicity and all types of diseases.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The study examined the effect of citizen participation on the performance of HCs in Nansana MC, Wakiso district. This chapter critically reviews literature related to citizen participation and performance of HCs. The review of literature has been done in accordance with the Representative Democracy theories that guided this study. The literature has been reviewed according to the objectives of the study.

2.2 Theoretical Review

The section presents the theories that underpinned the study. These are: theories of Representative Democracy and the Elite (Traditional) Theory, whose arguments are presented in the next sub-section.

2.2.1 Theories of Representative Democracy

This theory argues that the people affected by a particular decision should participate in the making of such decisions (Samah & Aref, 2011). Participation can, therefore, be construed as direct (by citizens) in the classical democratic sense or indirect - through (elected) representatives to voice citizens' views in a pluralist-republican democratic model as suggested by Kweit and Kweit (1986). The theory points out that policies in democratic processes should be evaluated against accessibility of the process and responsiveness of the policies to those it affects rather than on their mere efficiency or rationality to local governments (LG). This theory links to this study in the belief that citizen participation would lead to the outcome that citizens' desire in terms of availability, responsiveness and equity of access to public services.

2.2.2 The Elite (Traditional) Democracy Theory

The theory describes citizen participation as struggles for power with narrow elites. In this context, the responsibility of ordinary citizens is restricted to involvement in regular elections. It is also to ensure that elected leaders (governing elites) can be overthrown from power when the need arose; otherwise, citizens are regarded to be observers of the political game. The Traditional (Pluralist) Democracy Theory posits that policy-making in liberal democracies should be tailored to meet the interests of plurality of groups. This could more effectively mirror the benefits of a community through the inter-play of the different interest groups and organizations as observed by Dahl (1989). Politics is thus substantially a haggling process between representatives of different social common interests. Different types of expertise can be mobilized to serve as resources in such bargain. The combination of the Pluralist and Elite Democratic Theories together forms the concrete basis of most realistic work in comparative politics. These two variants together form the Theories of Representative Democracy.

Representative democracy theories have however, been criticized for their assumption of very limited possibilities of local citizen participation in public discourse, which leads to a de-politicized public with minimal influence over their own lives (Sclove, 1995). Theories of Representative Democracy are nonetheless, still invaluable in explaining citizen participation and service delivery and were adopted to guide this study.

2. 3 Citizen Participation and performance of health centers

The section presents related literature on citizen participation and performance of health centers. Literature is presented in three themes on participatory planning, participatory implementation and participatory monitoring and evaluation; and how the variables relate to performance of health centers.

2.3.1 Participatory Planning and Performance of Health Centers

Citizen participation in planning public services could better identify and enable better understanding of their needs. It could also stimulate information exchange between stakeholders, offer enjoyment of instilled public support for the proposed public service and enhance allocative efficiency. This is because citizens in most cases posess local knowledge and could suggest innovative alternatives that could result into more efficient allocation of resources to effectively address their local healthcare needs (Lu & Xue, 2011; Cavric, 2011; Lukensmeyer, Goldman & Stern, 2011). Many challenges that relate to planning can only be resolved when diverse individuals are engaged as they bring different perspectives, knowledge and information that could improve delivery of services including to the disadvantaged and marginalized sections of society (Sirianni, 2009; Batley & Rose, 2011; Pandeya 2015).

In terms of whether incorporation of local people's input in public decision making leads to a more effective and efficient provision of services, the minimal exertions to assess the participation-performance nexus offer mixed proof and have usually been restricted to individual case studies (Landre & Knuth, 1993; Kathlene & Martin, 1991; Moynihan, 2003) or compilation of case studies (Beierle & Cayford, 2002) which gap this study intends to fill by embarking on the specific case of selected HCs in Nansana M.C. Some studies show positive and significant relationship between participatory planning and performance of

public service provider institutions (Handley & Howell-Moroney, 2010) which appear to be premised on the theories of representative democracy - that those affected by a particular decision should meaningfully participate in making them (WHO, 2002; Urbinati & Warren, 2008).

Although the merits of participatory planning have long been recognized, public officials and community leaders have not been conversant with participatory methodologies to achieve desired results (Yang & Pandey, 2011; Bryson et al., 2013; Marzuki, 2015). This is perhaps why medicines are misappropriated in public HC by health workers in Wakiso district as reported by ACFODE (2015). To realize their desires, citizens should be provided with information and more understanding on public participation approaches to enable them participate in planning their future (Hornbein & King, 2012; Neshkova et al, 2012). In order to enhance the quality of public decisions, public involvement should include innovative approaches like citizen suits, formal public hearings and other forms of feedback (Sayce, 2013; NRC, 2008). Such approaches could complement the roles of elected leaders in planning for public services.

Scholars have increasingly recognized administrative constraint of costs associated with citizen participation (Bryson et al., 2013; Yang & Pandey, 2011; (Marzuki, 2015). Additionally, citizen involvement is time consuming and may delay decision-making since the public requires to be informed and even sensitized first to rationally participate in administrative planning processes. In the same vein, Irvin and Stansbury (2004) assert that ‘‘the cost per decision made by citizen participation groups is arguably more expensive than the decisions made by a sole administrator’’ with the suitable expertise and experience. Some scholars are apprehensive about citizen participation approaches because they could result into losing of control over the procedure according to Kweit and Kweit (1984) and Moynihan

(2003) and fear that most assertive citizens involved might represent individual interests against the broader public interests as suggested by Ebdon and Franklin (2004), Heikkila and Isset (2007); Simonsen and Feldman (2008) which could hamper the achievement of the desired citizen healthcare outcomes.

2.3.2 Participatory Implementation and Performance of Public Institutions

Participatory implementation of public services is significant for the democratization of social beliefs and for educating the public about government development programs (Neshkova et al. 2012). Studies have shown that it influences social changes in a community as it could enhance rational decision-making on matters that affect citizen's lives (UN, 2008; Neshkova & Guo, 2011; Marzuki, 2015). It could also produce inclusive development and equity-based decision-making as suggested by Bell, Adams and Brown (2002), Venugopal and Yilmaz (2009) and Mohanty (2010). It could also facilitate extension of improved services (UN, 2008; UNDP, 1993) and produce "outcomes that favor the poor and disadvantaged" (UN, 2008, p.23). Citizen participation in implementation of LG services could also improve performance of public institutions like HCs as it could minimize corruption as information about public resources would be disclosed to them facilitating more effective monitoring by citizens or their representatives (Porter & Onyach-Olaa 2001; Muriu (2014) Neshkova et al., 2012).

Civil Society Organizations (CSO) have increasingly been promoted as the organizational alternative to people-centered, inclusive and participatory development (Devas et al., 2001). They have been lauded to offer organized force with which LGs can engage, for example, in informal lobbying, negotiations and advocacy for change (Devas et al., 2001). Studies have however shown that CSOs have often not been strong in engaging with LGs (Blair, 2000). This has partly been attributed to the functional nature CSOs and inadequate government

support as well as weak links with community leaders, inadequate advocacy experience and low organizational capacity for accessing the less privileged (Blair, 2000; Devas et al., 2001).

The traditional and conventional means of direct citizen participation in implementation of public services include: serving on juries, attending public hearings, being part of commissions or task forces, responding to questionnaires or surveys, or filing complaints. Meanwhile, more innovative means of direct participation include large groups coming together to deliberate on pertinent issues that affect citizens to direct government attention and the use of online resources for cyber democracy. The effectiveness of this means of participation still appears mixed and institution-specific (Roberts, 2004; Easterly, 2010). Mechanisms to participatory implementation of public services include establishment of political quotas for minority groups to ensure their direct involvement in, for example, health sector management (Banerjee, Deaton & Duflo 2004; Kremer & Vermeesh 2005) in addition to (other) elected representation on governance/ management boards. This study found that HC were managed be management committees.

Previous studies on citizen participation have appeared to be methodologically biased as they have been based on information gathered from public (HC) administrators only (Yang & Pandey, 2011). Furthermore, several studies conducted have defined a range of analogous key aspects that are significant in defining the efficiency and usefulness of citizen involvement as suggested by Gaventa and Barrett (2012), Blair (2000), Devas and Gant (2003) and Putnam (1993). For example, Putnam (1993) has argued that the key role of civil society and the degree of social linkages are foremost bases for the effectiveness of citizen participation in Italy. Tools for refining answerability through improved openness and access to information include creation of information as of right through information legislations. At the local level, information campaigns about citizen's entitlements to information could be

advocated. Additionally, service quality standards should be established to ensure that citizens can easily evaluate the quality of services rendered to them to ultimately improve the performance of public service provider institutions (Gacitúa-Marió, Norton, & Georgieva 2009) like HCs.

Studies have suggested that citizen participation in implementation of public services could improve accountability of LGs by reinforcing traditional accountability systems as suggested by Blair (2000), Gaventa and Barrett (2012) and Devas and Grant (2003). It could also increase public confidence as demonstrated by Wang and Wart (2007), Stansbury and Irvin (2004) to bolster the legitimacy of state choices and actions (UN, 2008, Farazmand, 2009). Citizen involvement could also act to control the deficiencies of government officials (Kaufmann & Bellver, 2005; UN, 2008).

Participatory implementation of public services has, however, been found to have their limitations (Fung & Wright, 2003; Osmani, 2007). Several studies have discovered that citizen involvement can yield undesirable intermediate results as found out by Barrett and Gaventa, (2012) and Sharma and Rocha-Menocal (2008). As Gaventa and Barrett (2012) posit, citizen involvement may lead "to a sense of disempowerment and a reduced sense of agency, or to new knowledge hierarchies." It might as well be "meaningless, tokenistic, or manipulated. … [or] can contribute to new skills and alliances which could be used for corrupt and lead to non-political ends or get captured by elites." In addition, participatory implementation could also constrain meeting of citizen expectations in consonance with Irvin and Stansbury's (2004) findings that citizen involvement may well require more time hence lead to higher overheads and increased likelihoods of inaccurate judgments. It might also result into elite apprehension and engender the search of individual benefits by those in authority. Besides, citizen participation may also lessen the representativeness of nationals

and condense their authority in making public decision as found out by Fung and Wright (2003) and Osmani (2007).

2.3.3 Monitoring and Evaluation and performance of Public Institutions

The purpose of accountability is that citizens (principal) hold the potential to track the performance of their agent (service providers). Therefore, performance of the agent needs to be closely monitored against the original directive and the capacity to administer authorizations in case of substandard performance needs to exist (Camargo & Eelco, 2010). The mounting pressure to concentrate on implementation processes and outcomes in delivery of public services could reinforce the importance of improving monitoring and evaluation systems. Results-based approaches where funds disbursement is linked to measurable outcomes (results) like number of children vaccinated at health facilities have been adopted and implemented by, for example, the World Bank in its health-financed projects in many developing economies. These frameworks ordinarily demand for a robust function of population in monitoring and evaluation to guarantee that planned objectives remain attained (Ringold, Holla, Kaziol, & Sranivasan, 2012).

The notion that citizens can use processed data to enable access to improved amenities is also in consonance with legitimate frameworks to service provision (Norton, Georgieva & Gacitúa-Marió, 2009). According to Lee and Odugbemi (2011) it was noted that multi-national development institutions have turned out to be infatuated with accountability, nonetheless they emphasize the danger that it has become a buzzword. In the context of delivering services, answerability can be applied bottom-up by NGOs, CSOs, media and the citizens (Griffin et al., 2010). Civic accountability is a different term for bottom-up kind of answerability that involves the citizens, CSOs and community among others. It also denotes to the set of instruments that the population can apply to stimulate the eminence of delivering

services by holding the service providers answerable. To effectively perform this, citizens need to be informed personally and communally about their entitlements, amenities and gains they are mandated to obtain, the quality standards they should anticipate and remedial measures they can apply when things go wrong (Ringold, Holla, Kaziol, & Sranivasan, 2012).

Some tools like scorecards could provide indicators of performance although they require effective interactions between citizens and frontline service providers. These technocrats require enticements and ability to give timely feedbacks to citizens. Civil society players also have key function in the operationalization of civic answerability intermediations in assisting to make evidence readily available and accessible. They can collect data, ensure capacity building on budget knowledge, and assist nationals file complaints and access redress measures (Odhiambo, 2014). Additionally, report cards are explained as form of information campaign that provides proportional material facts on amenities. In the Organization for Economic Co-operation Development countries, report cards have been fully exploited as an answerability technique principally for effective health service delivery. They often cartel stakeholder satisfaction investigation with impartial pointers employed in comparing amenities alongside one another. Tallies and civic audits are supplementary vigorous material facts intermediations that encompass physical collaborations between nationals and service providers. They also enable joint deed of consumers of services and providers (Ringold, Holla, Kaziol, & Sranivasan, 2012).

Civic audit refers to a type of societal monitoring and evaluation that permits nationals who access and obtain a service to review and audit the material facts reported by the service provider against processed data gathered from beneficiaries of the amenity. This type of monitoring and evaluation could appraise several factors of service delivery procedures such

as whether funds apportioned are actually expended on the activities and intended beneficiaries at the health centers; whether individuals who passed the test of eligibility actually received the gains; and whether service providers showed up for work (ACFODE, 2014). The outcomes of the audit are often communicated through community meetings, which are usually attended by beneficiaries as well as state officials tangled in the implementation and management of services and providers respectively. India's National Rural Employment Guarantee Scheme, for example, integrates an active group of projects of social audits (Ringold, Holla, Kaziol, & Sranivasan, 2012).

Citizens could be considered principals, and politicians being their go-betweens who are mandated to extend common services on their behalf, and material facts about the performance of politician's permits electorates to recompense or castigate politicians during elections (Preston & Besley, 2007). There are abundant realistic facts from long term effects in less developed and developing countries indicating that electorates take such facts into consideration (Pande, 2011). Greater print media astuteness proportions in India improved governments' responsiveness to floods and long droughts. Besley and Burgess (2002) in their study also discovered that just as media centres reinforced the impact of disbursement audits on an incumbent's opportunities of being re-elected through municipal elections in Brazil (Ferraz & Finan 2008).

A study in Kenya for example found that, when parents are enlightened to track activities of teachers on contracts in their teaching institutions and hold performance appraisals, test scores improved in one year. This learning benefit, however, vanished, after one year, when the teachers' contracts ended (Duflo, Dupas & Kremer 2010) suggesting that parents might not have sustained tracking their activities. In several studies, the correlation between service providers and consumers didn't change at all. But the information crusades utmost probable

stirred claim for amenities that were not being utilized. An information crusade in India, for example, informed citizens of their entitlements to free health services in public health centers, and proof from a randomized periodic assessment proposed that the take-up of definite authorized services improved dramatically, but only for services that tangled consumers coming to the service facilities. The intermediation disclosed no vital long term effects on services that needed service providers to leave their service facilities, nor did target consumers increase their involvement in local politics (Pandey et al. 2007).

2.4 Summary of Literature Review

The literature reviewed reveals that the effect of citizen participation on performance of public institutions remains an issue that demands further investigations as results are mixed requiring institution-specific studies. Methodologically, selection of respondents has posed a bias that needed to be addressed. For example, some studies relied exclusively on the perceptions of health workers leaving out patients views in their studies. This study focused on Nansolo, Nabweru and Nakuule HCs in Nansana MC in Wakiso district and drew respondents from HC staff and management, patients and/ caregivers, CSO and NGOs to provide a more holistic perspective.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This study examined the effect of citizen participation on the performance of HCs in Nansana MC, Wakiso district. This chapter presents a description of the selected research methods, approaches that were adopted in this study and their justification. They include the research design, research approach and population of study. They also include sampling strategies, methods for data collection and instruments, data analysis and ethical considerations. In general, this chapter presents the road-map for the study.

3.2 Research Design

This study adopted the case study research design. A case study research design is a research strategy that focuses on exploration of complex phenomena and related context (Amin, 2005). It enabled an in-depth investigation into the particular situation/ phenomenon under investigation (Creswell, 2010; Amin, 2005), in this case citizen participation and performance of HCs. The study also adopted a survey strategy which involved collection of data from a representative subset (sample) of the population. This research design saved time in a study that involves a large geographical coverage like this study and is less costly as data was collected only once during the data collection period as suggested by Amin (2005).

The study involved both quantitative and qualitative research strategies. Quantitative data are any data that are numerical like the number of patients attending treatment in HCs in a year. Qualitative data on the other hand are non-quantified data (Sekaran, 2003). In particular, quantitative approaches have been seen as more scientific and objective. Qualitative strategies on the other hand were used to explore attributes like human behaviors which could

not be quantified yet important (Creswell, 2010). The two approaches were adopted to complement each other.

3.4 Study Population

The accessible population of this study was 222 drawn from potential respondents at three HCs that this study covered. The population of study included HC staff namely Clinical officers (8), nurses (6), Mid-wives (4), Nursing Assistants (8), HC Management Committee members (9) and Village Heath Workers (VHW) (32). The non-staff members covered included patients and care givers (145), CSOs (5) and NGOs (5) working on healthcare sector in Nansana MC.

3.5 Sample Size and Selection

The sample size for this study was 139 determined using statistical tables developed by Krejcie and Morgan, cited by Amin (2005), Table 3.1.

Table 3.1: Sample Size and Selection

Category	Access Pop	Sample Size	Sampling technique
HC Management committees	9	3	Purposive
Clinical officers	8	3	Purposive
Nurses	6	6	Purposive
Mid-wives	4	4	Purposive
Nursing Assistants	8	8	purposive
Village Health Workers	32	22	Convenience
Patients / care givers	145	88	Convenience
CSOs	5	3	Purposive
NGOs	5	2	Purposive
Total	**222**	**139**	

Source: Survey data

3.6 Sampling Techniques and Procedure

This study involved non-probability (purposive and convenience) sampling strategies. Purposive sampling refers to selecting individual cases that are considered knowledgeable about the phenomenon under study as suggested by Amin (2005) from which they could be excluded if probability sampling like random sampling was used. Purposive sampling was

intentionally used to select HC top management teams/committees, NGOs and CSOs. Individuals in these population categories were considered to possess and were found to have vast and relevant information. This sampling method therefore permitted the researcher to use his judgment to select respondents deemed to have information relevant to this study. Convenience sampling technique on the other hand, was applied to select members of HC management committees and patients. Since the two categories do not work with the HCs, they are expected to be mobile implying that the researcher was only able to select those that were around during the study, where Amin (2005) has suggested such categories of respondents could be included using convenience sampling. Some patients were however not in position to provide the required information as their health conditions could not allow.

According to Creswell (2018, p.382) "It is also possible in survey research to study the entire population because it is small and members can be easily identified," this is referred to as a census. Due to the small staffing levels in the selected HCs, the respondents were selected purposively but a census was carried out for Clinical Officers, Nurses, Midwives, Nursing Assistants and VHWs. In convenience sampling the participants were selected because they were willing and available to be studied as suggested by Creswell (2010). In this case, the researcher cannot say with confidence that the individuals were representative of the population, the scientific rigour to ensure that each one selected had an equal chance of being selected without the influence of the researcher. But as it was difficult to obtain patient lists and to predict that they would come to the HC, this strategy had to be adopted for convenience purposes.

3.7 Data Collection Methods

This study employed both primary and secondary methods of data collection. In particular, Documentary review, Questionnaire survey, Interviews and Focus group discussions (FGD)

data collection methods were adopted in this study. It was anticipated that the combination of these methods would secure requisite methodological triangulation.

3.7.1 Documentary Review Method

Documentary review method according to Payne and Payne (2004) is the analysis of relevant documents that contain information about the phenomenon under study. Payne and Payne (2004) further define documentary review method as a method used to categorize, investigate, interpret and identify the limitations of physical sources like human behavior. Data collection involved review of relevant documents to obtain secondary information. Documents reviewed in this study included District Quarterly and Annual Reports, Journals and other related published materials.

3.7.2 Questionnaire Survey Method

The questions that were asked in the survey were based on the fact that the variables like respondents' views, opinions, perceptions and feelings could not be observed (Sarantakos, 2003). Questionnaire survey method was used by the researcher because it was less expensive to use to collect data and encouraged respondents to freely answer questions that enabled collection of vast amounts of data within a short time (Amin, 2005). Documents containing the required information were however, difficult to obtain and locate, a concern also raised by Creswell (2010). This was however, overcome by construction of an appropriate literature map to guide the researcher locate secondary data.

3.7.3 Interview Method

The interview data collection method adopted in this study was based on one on one interactions with respondents in a bid to generate detailed and first-hand information. This involved the researcher personally interacting and relating with the selected and willing

respondents with a set of predetermined questions on a one by one basis. Non-directive and in-depth interviews were carried out to cover broad thematic areas of the study as suggested by Amin (2005). This method was used to supplement the other methods to improve the quality of data that was collected by collecting data from HC staff, NGOs and CSOs.

3.7.4 Focus Group Discussion

A focus group discussion (FGD) involved holding discussions with groups of people typically six to eight (Amin, 2005). This method was useful to collect data when time was limited and respondents were reluctant to provide information at individual level as suggested by Creswell (2010). Focus group discussions were justifiable as the researcher was able to elicit shared understanding from a group of individuals as well as to obtain views from specific group of people through discussions. This method was used to collect shared information from patients and care givers.

3.8 Data Collection Instruments

For every data collection method there was a corresponding instrument. Presented in this section therefore is a description of the different data collection instruments and their justification for the study.

3.8.1 Documentary Review Checklist

Documentary review checklist contained a list of relevant documents enlisting information about the phenomenon under study (Bailey, 1994). In exploring this method the researcher developed a documentary review checklist to guide collection of data from records and other relevant internet sources. In order to achieve measurable data, the items that were contained in the checklist were restricted to those that could be consistently secured from a wide

number of history cases or other records. Among other relevant documents that the researcher reviewed were journal articles, published documents and presented papers.

3.8.2 Questionnaires

Questionnaires were selected in this study because they covered a vast geographical area that made it appropriate for the researcher to collect the required data in the shortest time possible (Amin, 2005). The questionnaires were composed of a set of systematically structured questions that were employed to gather quantitative information from respondents. As a significant research tool for collecting data, questionnaires were used to perform their key function of measurement and to homogenize questions so that the same questions are asked in the same way repeatedly (Mugenda & Mugenda, 2003; Oppenheim, 2006). Questionnaires were used as the major data collection technique in surveys and yields to quantitative data. Due to use of both close-ended and open-ended questions, the questionnaire was used to obtain quantitative, qualitative and exploratory data (Dornyei, 2001). The researcher developed and administered one set of structured questionnaires to collect data from community health workers and another similar one for patients/ care givers. The close-ended set of questionnaires used were designed by the researcher to be scored on a five point Likert scale ranging from 1= strongly disagree, 2 = disagree, 3 = not sure, 4 = agree and 5= strongly agree (Appendix I). Questionnaires were chosen in this study because the study covered a large geographical area that made the use of questionnaires appropriate because it was less expensive, yielded quantitative data and attracted higher response rates as suggested by (Amin, 2005).

3.8.3 Interview Guide

Primary qualitative data were gathered using interview guide instrument and guided the researcher in carrying out interviews. The interview guide was employed for non-directive

and in-depth interviews that had the flexibility of enabling the researcher to probe and obtain pertinent information (Eyles, 1989). It contained broad themes that were used to collect data from respondents. In this study the interview guide served as a suggestive reference and prompter during interviews to help focus attention on salient points. It was developed by the researcher and employed to gather data from key informants like and NGO staff.

3.8.4 Focus Group Discussion Guide

A FGD guide as an instrument was used for collecting qualitative data from a group of people through a group discussion (Creswell, 2010). The guide contained a set of questions by theme, which enabled the researcher as the moderator to focus on the salient areas of investigation so that discussions are not diverted away from its intended course. A FGD guide was developed by the researcher to gather data from a group of patients and care givers in this study.

3.9 Data Quality Control

In order to ensure quality of the collected data, the data collection instruments were tested for validity and reliability as detailed in the sub-sections below.

3.9.1 Validity

To establish the validity of the research instruments, they were referred to experts to evaluate the relevance – the number of items considered relevant from a set of questions asked as indicated in Table 3.2.

Table 3.2: Validity of research Instruments

Variables	Tot. No. of Items	Expert 1	Expert 2
		No Relevant items	**No Irrelevant items**
Performance of HCs (Dependent variable)			
Availability of HC			
Responsiveness to citizens needs			
Fairness and equity	9	8	7
Participatory M & E (Independent Variables)			
Participatory planning	7	6	6
Participatory implementation	8	6	7
Participatory M & E	8	6	6
Total	32	26	26
Mean (Item rated relevant? total no. of items)		0.8125	0.8125
Mean score 1 & 2 (0.8125 + 0.81 /2= 8.125			0.8125

Source: Primary Data

From Table 3.2, the coefficient of Validity Index was found to be 8.4. According to Amin (2005) a coefficient of validity index of 0.7 and above is acceptable. The coefficient of validity index in this study was above 0.7 and the instruments were therefore considered valid and results deemed to be valid.

The content of validity Index (CVI) was used to compute the validity of the research instrument from the following formula:

$$\textbf{CVI} = \left(\frac{\text{Items rated relevant}}{\text{No. of items in questionnaire}} \right)$$

A CVI was acceptable because after computation it was above 0.7 (Amin, 2005).

3.9.2 Reliability

Reliability of a data collection instrument related to the consistency or stability with which data was collected (Mugenda & Mugenda, 2005). To increase content reliability, the researcher pre-tested the questionnaires on fifteen respondents in Namirembe Hospital and

reviewed it before data collection was undertaken. Cronbach's Alpha coefficient was employed to determine the internal reliability of the instrument in this study which was tested in its entirety, while the sub-scales of the instrument were tested independently as indicated in Table 3.3.

Cronbach's alpha reliability coefficient ranges between 0 and 1. The closer the coefficient to 1.0 the greater the internal consistency of the items in the scale and vice versa. To test the reliability the researcher based on the following formula,

$$\textbf{Alpha} = rk / [1 + (k - 1) r]$$

Where k was the number of items considered and r, the mean of the inter-item correlations. The size of alpha was determined by both the number of items in the scale and the mean inter-item correlations. The survey instrument was tested in its entirety, while the subscales of the instrument were tested independently.

Table 3.3: Reliability of Research Instruments

Variables	**Tot. No. of Items**	**Cronbach alpha**
Performance of HCs (Dependent variable)	9	0.712
Participatory planning	7	0.753
Participatory implementation	8	0.745
Participatory M & E	8	0.689
Total	32	2.899
Mean		**0.72475**

Source: Primary Data

Cronbach alpha was found to be 0.72. According to Mugenda and Mugenda (2005) an instrument is reliable when Cronbach alpha is 0.7 and above, this instrument had Cronbach alpha above 0.7 and data collected using the instrument was thus considered reliable.

3.10 Procedure for Data Collection

The researcher obtained a letter of introduction from Uganda Management Institute introducing him to the Town Clerk of Nansana MC. The researcher arranged and met the Town Clerk to explain the purpose of the study and to request to be permitted to carry out the study. The researcher was permitted and he arranged to meet the Municipal Public Health officer, staff and patients/ caregivers to prepare them as respondents for the survey. Research assistants were trained in the use of the instruments and pre-tests were carried out on 15 respondents in Namirembe Hospital. The instruments were reviewed to improve on the questions that had not come out clearly before data collection was commenced with the help of the in-charge of each of the three HCs.

3.11 Data Analysis

The study collected both qualitative and quantitative data and thus, qualitative and quantitative data analysis techniques were deployed as elaborated in the sub-sections below.

3.11.1 Qualitative Data Analysis

To analyze qualitative data, responses were organized into statements that generated useful interpretations and conclusions according to each of the research objectives (Sekaran, 2003). Qualitative data analyses were done using content and thematic analysis. Each interview response was reviewed, sorted and classified into themes that were related. Data were evaluated and analyzed to determine consistency, credibility and usefulness of the information to support the qualitative data requirements for this study.

3.11.2 Quantitative Data Analysis

When the data collection instruments were returned, data were coded, entered on computer, cleaned and edited. Data analysis involved the use of Statistical Package for Social Scientists

(SPSS). Data were summarized as descriptive statistics: frequencies, mode, mean, standard deviation and percentages. Inferential statistics involved correlation analysis (Pearson Product Moment Correlations) and linear regressions to determine relationships between the independent and the dependent variables (Mugenda & Mugenda, 1999).

The Pearson Correlation Coefficient was denoted by rho, r. Its formula was based on the standard deviations of the x-values and the y-values representing the two items (variables) about which relationships were investigated. The formula below was used.

$$r = \frac{n(\Sigma xy) - (\Sigma x)(\Sigma y)}{\sqrt{[n\Sigma x^2 - (\Sigma x)^2][n\Sigma y^2 - (\Sigma y)^2]}}$$

The resulting value depicts whether changes in one variable caused changes in the other as defined by Gajarati (2003) who interpreted that coefficient rho could range between +1 to -1 where, a +1 indicates a perfect correlation meaning, a change in one item resulted into a corresponding change in the other item. A correlation of -1 was a perfect but negatively affected the other by a similar magnitude but in opposite directions. Pearson Product Moment coefficient, rho, was used to indicate the direction and strength of the relationship between participatory planning, implementation and M&E and performance of HC. Probability (p) values were used to test the significance of each of the exploratory variables at alpha levels one, five and ten percent.

3.12 Measurement of variables

The independent variable in this study was citizen participation (participatory planning, implementation and M&E) while the dependent variable was performance of HCs (availability of healthcare services, responsiveness to citizen's needs and fairness and equity of healthcare provision). To measure these variables, the researcher developed a five-point

Likert scale as suggested by Mugenda & Mugenda, (1999; p. 74) to capture respondent's level of agreement with statement as, strongly agree = 5, agree = 4, neutral/ not sure = 3, disagree = 2, and strongly disagree = 1. Additionally qualitative data collection instruments were used to collect secondary data from key informants and discussions with focus groups.

3.13 Ethical Considerations

Research ethics demands that ethical practices are pursued in all steps of the research because ethics has become a more pervasive stretching throughout the research process. Ethics should, therefore, be a primary consideration of the researcher's agenda (Hesse-Bieber & Leavy, 2006). To comply with ethical conduct, the researcher identified himself honestly to respondents and explained the purpose of the study and sought respondents' consent to participate in this study. Identification of respondents involved use of unique identification numbers to identify respondents during data collection to protect respondents and ensure integrity of the research process as suggested by Creswell (2010). In compilation of this report all authorities whose work was referred to were duly acknowledged.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 Introduction

This study investigated the effect of citizen participation on performance of selected HCs in Nansana Municipality in Wakiso district in Uganda. This chapter presents the response rate, socio-democratic characteristics of respondents, Pearson Correlation and regression analyses according to the objectives of the study.

4.2 Response Rate

The response rate findings for this study are indicated in Table 4.1.

Table 4.1: Respondent Rate

Instruments	Target response	Actual response	Response rate
Questionnaire	113	92	88.46%
Interview guide	8	6	75.00%
Focus Group Discussion guide	18	14	77.78
Total	139	112	86.15%

Source: Primary data, 2018

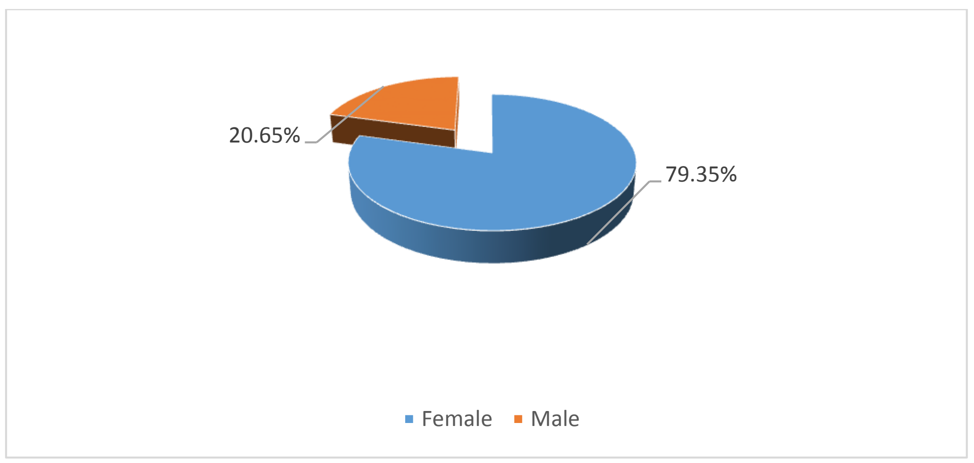
From Table 4.1 above, a total of 113 questionnaires were administered to respondents out of which 92 were returned and validly completed providing a response rate of 86.15%. Then out of the 1 8 key informants scheduled for interviews in this study, only 6 were actually interviewed giving a response rate of 75.0%. Focus group discussions involved 14 out of the targeted18 implying a response rate of 77.78%. Overall out of 139 targeted respondents, only 112 were actually observed giving a total study response rate of 86.15%. The response rate was deemed good enough being above the 50% recommended by Mugenda and Mugenda (2003).

4.3 Background information of Respondents

The background information of respondents was covered by the study. Among these characteristics included gender, age and level of education.

4.3.1 Gender of Respondents

To understand the gender distribution of the respondents, the researcher observed their gender characteristics and the results are presented in Figure 4.1 below.



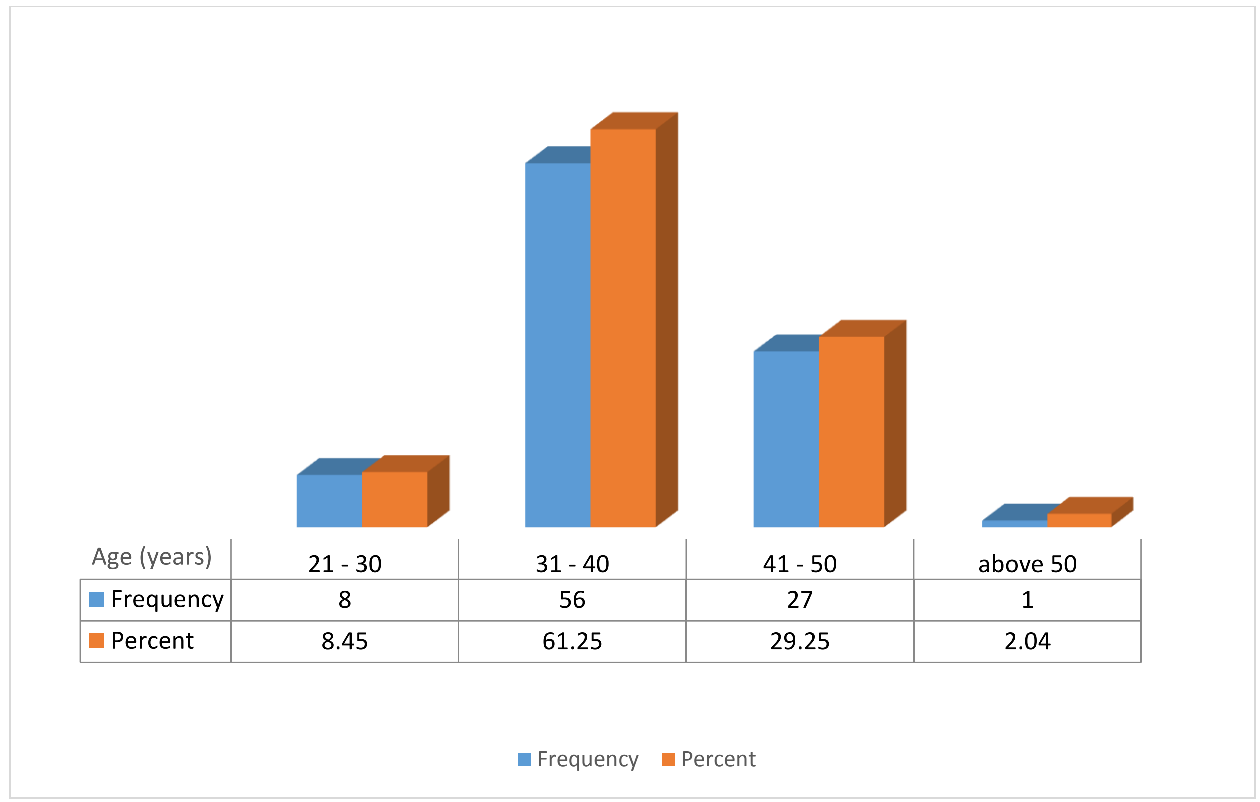
Source: Primary data, 2018

Figure 4.1: Gender Distribution of Respondents

From Figure 4.1, it is presented that the majority of respondents in the study were females constituting a total of 79.35%. Males on the other hand, constituted 20.65% of the respondents. The implication of this finding was that notwithstanding the disparity in percentages of female and males who participated the study, the study was representative since the views of both female and male were captured.

4.3.2 Age Structure of Respondents

To find out the age structure of the respondents, the respondents were requested to state their ages and below are the results are presented in Figure 4.3.



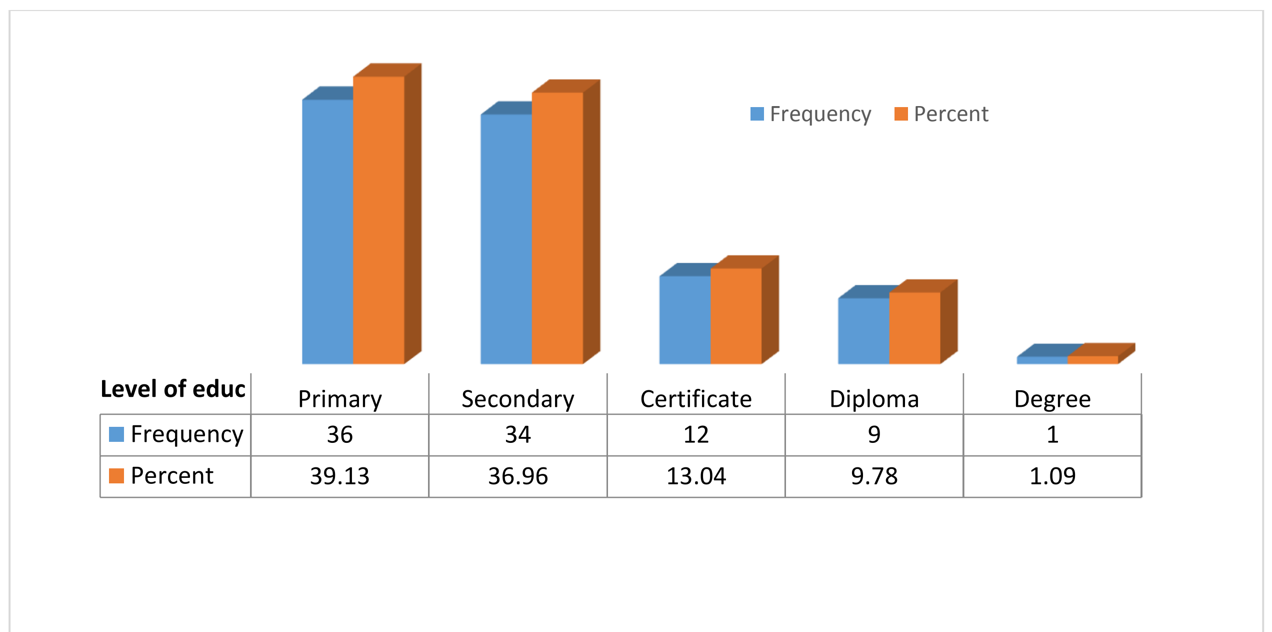
Source: Primary data

Figure 4.3: Age of Respondents

From Figure 4.3, it was found out that majority of the respondents (90%) were between the age brackets 31 to 40 and 41 to 50.. The implication of this finding is since majority of respondents were over 30 years of age, majority of respondents were mature enough to appreciate and understand the study

4.3.3 Level of Education of Respondents

Respondents were also requested to state their level of education and results are shown in Figure 4.4in detail.



Source: Primary data

Figure 4.4: Level of Education of Respondents

Figure 4.4 indicate the respondents who had attained primary school e constituted 39.13%. Those who had attained secondary level constituted 36.69% respondents while 13.04% of the respondents were certificate holders. Those had Diploma qualifications were 9.78% while 1.09% had a degree in Nursing. Basing on the above findings, all the respondents had at least attended school and had cognitive capacity to understand and appreciate the study interest and so, could be relied upon.

4.4 Empirical Findings

The research findings in this section are presented chronologically according to the objectives of the study. These findings were thus obtained on the effect of participatory planning on performance of Nansolo, Nabweru and Nakuule HCs in Nansana MC; effect of Participatory implementation on performance of Nansolo, Nabweru and Nakuule HCs in Nansana MC and the effect of participatory M& E on performance of Nansolo, Nabweru and Nankuule HCs in Nansana MC. Therefore, to understand the effect of citizen participation on performance of selected HCs in Nansana MC, the selected respondents were introduced to different predetermined conceived statements as per each variable to their views and below are the findings that were found on each dimension.

In order to bring out a clear understanding of the relationship the research first discussed the dependent variable in this study which is performance of health Centers.

4.4.1. Performance of Health Centres

In this study the dependent variable was performance of HCs. The dimensions of performance of HC in this study were availability of healthcare, responsiveness to citizen's needs and fairness and equity of provision of healthcare services. These dimensions were investigated based on the perception of respondents. Respondents were asked to evaluate statements relating to each of the indicators under Performance of HCs using a five point Likert Scale as follows: Strongly disagree = 1; disagree = 2; not sure = 3; agree = 4 and strongly agree = 5 as indicated in Table 4.2.

Table 4.2: Perceptions on Performance of Health Centres

A. Healthcare Performance	Perception of Respondents (%)					Score	Deviation
(i) Availability of HC Services	**SD =1**	**D=2**	**NS=3**	**A**	**SA=4**	**Mean**	**Stan. Dev.**
HC services I require are available	4.3	6.5	15.2	34.8	39.1	3.98	1.099
HC services I require are provided	3.3	7.6	10.9	34.8	43.54	4.08	1.071
HC services are accessible to me	4.3	5.4	13	21.7	55.4	4.18	1.128
(ii) Responsiveness to citizens Needs							
My HC needs are often taken into account	1.1	8.7	13	34.8	42.4	4.09	1.181
The quality of HC services address patients' needs	6.5	14.1	27.2	29.3	22.8	3.48	1.125
Patients HC expectations are often met	4.3	9.8	22.8	32.6	30.4	3.75	1.139
Patients are satisfied with HC services	3.3	9.8	20.7	26.1	40.2	3.9	1.8
(iii) Fairness and Equity							
HC services are provided to patients without discrimination	7.6	7.6	26.1	23.9	34.8	3.71	1.182
HC services are provided to all in need	6.5	7.6	26.1	28.3	31.5	3.71	1.82

Source: Survey Data

Results in Table 4.2 shows that the means for each indicator was above 3.5 (above not decided), the implications of this finding is that respondents were in agreement with the statements in the questionnaire. In terms of individual indicators, the majority (73.9%) of respondents perceived that the healthcare services I require are available (agree 34.8% and strongly agree 39.1%) with a mean of 3.98 and standard deviation of 1.099. The implication of this finding is that when patients seek medical attention at the HCs, the treatment they require and medicines/care to be provided are in stock/ provided to meet their healthcare needs. The majority (78.34%) of respondents considered that the h healthcare services I require are provided (34.8% and strongly agree 43.54%) with a mean of 4.08 and standard deviation of 1.071. This implies that when patients go to attend treatment, they obtain the healthcare needs from the HCs. This means that the HCs are equipped to provide the kind of healthcare services that patients demand. In terms of accessibility of healthcare services, the majority of respondents felt that the healthcare services are accessible to me. The implication of this finding is that the distribution of HCs in the municipality places them within easy

reach by patients in terms of physical distance. This, therefore, means that when patients require medical attention they can easily travel (short travel distance or affordable transport fare) to the health facilities to receive medical attention or receive attention through healthcare out-reach activities by VHWs (with the backing of professional HC staff) who are also distributed within the community.

The majority (87.2%) of respondents perceived that my HC needs are often taken into account (agree 34.8; strongly agree 42.4%) with a mean of 4.09 and standard deviation of 1.181. This implies that healthcare workers are keen to attend to individual requirements of patients in terms of healthcare needs. This suggests that the HCs are responsive to the individual patient's healthcare needs. In terms of healthcare service provision, the majority (52.1%) of respondents perceived that the quality of healthcare services address patients' needs (agree 29.3%; strongly agree 22.8%) with a mean of 3.48 and standard deviation of 1.125. The implication of this finding is that healthcare workers in the HCs prioritize provision of high quality healthcare for patients. This suggests that patients will be willing to continue to attend treatment in these HC as they perceive that high quality healthcare services are provided. The majority (63%) of respondents agreed that patients HC expectations are often met (agree 32.6%; strongly agree 30.4%) with a mean of 3.73 and standard deviation of 1.139. The implication of this finding is that their healthcare requirements are met based on their perception on what the HC facilities can provide. This means that they are satisfied with the kind of services they anticipate to obtain in the facilities. In terms of satisfaction with healthcare services, the majority (66.3%) of respondents felt that patients are satisfied with HC services (agree 26.1%; strongly agree 40.2%) with a mean of 3.9 and standard deviation of 1.8. This finding implies that the responses with which the facility targets the client patients are in conformity with their healthcare needs.

The majority (68.7%) of respondents agreed that healthcare services are provided to patients without discrimination (agree 23.9%; strongly agree 34.8%) with a mean of 3.71 and standard deviation of 1.182. The implications of this finding are that healthcare services are provided without socio-economic disparities of patients. This, therefore, means that healthcare entitlements cut across the socio-economic divide. In terms of universality of healthcare service provision, the majority (59.8%) respondents agreed that healthcare services are provided to all in need (agree 28.3%; strongly agree 31.5%) with a mean of 3.71 and standard deviation of 1.82. This implies that healthcare services in the facilities are provided with fairness and impartiality. This means that healthcare services are provide equitably with even handedness to all patients who come to seek medical attention at these facilities.

The responses above tend to suggest that healthcare services are available, the HC surveyed are responsive to patients' needs and patient are fairly attended to and are not discriminated due to socio-economic status. These findings are in consonance with key informant perceptions that, despite budgetary constraints it is the interest of HCs to ensure that citizens' needs are provided.

One key informant said,

> *"...the focus of our facility is to make sure that our patients come back. When patients come for medical care and we provide the care that satisfy them, then they will always come back. Our patients and the local community have some confidence in us and they come back..."* (Key Informant Interview).

In a focus group discussion, the group contended that the health facility was within reach, One said, "*… we can walk to the hospital, it is not far or even we can use boda boda which costs less than two thousand shillings only…*" The implication is that the pattern of HC distribution provides easy access to the facilities in terms of distance and cost of transport.

4.4.2 Participatory Planning and Performance of HCs

Presented under this section are findings for the effect of participatory planning on performance of health centers for descriptive and inferential statistics. The findings are presented objective by objective.

Respondents were asked to evaluate statements relating to each of the indicators under Participatory planning in HCs using a five point Likert Scale as follows: Strongly disagree = 1; disagree = 2; not sure = 3; agree = 4 and strongly agree = 5 as indicated in Table 4.3.

Table 4.3: Participatory Planning and Performance of HCs

Independent variable	**Perception of Respondents (%)**					**Score**	**Deviation**
b) Participatory planning	SD =1	D = 2	NS =3	A =4	SA=5	Mean	St. dev
Patients get access to information about HC (plans)	10.9	8.7	19.6	31.5	29.3	3.6	1.293
I have ever given my views on hC to management	9.8	7.6	19.6	27.2	35.9	3.72	1.295
Citizens views are considered in the planning process	6.5	14.1	28.3	31.5	19.6	3.43	1.151
Citizens are provided opportunities to attend meetings to discuss hc issues	10.9	20.7	18.5	32.6	17.4	3.25	1.272
Citizens priorities are often considered	4.3	10.9	22.8	27.2	25	3.38	1.349
Citizens inputs have often been taken in making healthcare decisions	4.3	8.7	25	41.3	20.7	3.65	1.042
Community partners have been provided information and tools required to identify needs, set priorities	8.7	9.8	19.6	34.8	26.1	4.14	1.293

Source: Survey Data

From Table 4.3, all responses were scored 3.2 and above. This implies that respondents in general agreed with the statements in the questionnaire. In terms of access to information on healthcare plans, the majority (60.8%) of respondents' agreed that patients get access to information about healthcare plans (agree 31.1%; strongly agree; 29.35%) with a mean of 3.6 and standard deviation of 1.293. This implies that citizens are provided opportunity to access to planning information. This provides them (citizens) not only with information about plans but even the basis for assessment of implementation based on planning information. The majority (63.1 %) of respondent agreed that I have ever given my views on healthcare to management (agree 27.2%; strongly agree 35.9%) with a mean of 3.72 and standard deviation

of 1.295. The implication of this finding is that citizens' views form the structure of healthcare planning of the health facilities. This means that healthcare outcomes could be enormously improved enhancing the performance of HCs.

On citizen participation in meetings, the majority (51.1%) of respondents agreed that Citizens views are considered in the planning process (agree 31.5%; strongly agree 19.6%) with a mean of 3.43 and standard deviation of 1.151. Citizen views when considered could help prioritize citizens' needs in the planning process. On opportunities to attend planning meetings, the majority (60%) of respondents perceived that citizens are provided opportunities to attend meetings to discuss healthcare issues (agree 32.6%; strongly agree 17.4%) with a mean of 3.25 and standard deviation of 1.272. Opportunities to attend meetings suggests that planning information can be shared among stakeholders. This is one of the basic features of citizen participation as citizens will probably be in position to ascertain the kind of services they anticipate to receive within the planning horizon, while during and at the end of implementation of the plan they will also be able to monitor and evaluate performance based on targets established at the planning stage.

The majority (60.0%) of respondents agreed that citizens priorities are often considered in the planning process (agree 32.6%; strongly agree 17.4%) with a mean of 3.25 and standard deviation of 1.272. This finding suggests that the planning process in the HCs are participatory. This finding suggests that citizens are likely to attain their healthcare needs in these HCs. This is further reinforced by the perception by the majority (62%) of respondents that citizens' inputs have often been taken in making healthcare planning decisions (agree 41.3%; strongly agree 20.7%) with a mean of 3.65 and standard deviation of 1.042. On provision of information to community partners, the majority (50.9%) of respondents agreed that community partners have been provided information and tools required to identify

citizens healthcare needs and priorities (agree, 34.4%; strongly agree, 26.1%) with a mean of 4.14 and standard deviation of 1.293. This finding suggests that community partners are a mouth piece through which citizen's desires can be articulated. This approach is one way of citizen involvement in the planning process that could enhance performance of HCs.

In view of the responses regarding participatory planning, respondents perceive that they participate in the planning process as their views are taken into account, participate in planning meetings and community partners' support them so that their views are incorporated into plans. Key informants contented that planning for healthcare activities takes into account the needs of citizens as they use various means to collect citizens' views. A key informant said

> "*…we have Village Health Workers in the community, we conduct healthcare out-reach activities, and even hold monthly meetings with community leader to receive reports and views from the community …We also hold monthly management committee meetings where the community is represented by elected leadership…this is only one way their views are brought to the health facility planning process…in addition to village meetings… "*

Civil Society organizations and NGOs also participate in sensitization, identification and consolidation of community priorities while some of them do so by living in the communities for considerable period of time. Organizations like Mild May Uganda also support communities in sensitization through good-will ambassadors. One key informant said,

> "*…we send our ambassadors to work within the community for some time to support communities with identifying their priorities which we share with healthcare implementers and other stake holders in the sector. Living within*

the communities provides opportunities to get the real view from citizens' perspectives…" (Key Informant Interview).

4.4.2.1 Correlation between Participatory Planning and Performance of Health Centers

Correlations were run between participatory planning and performance of HCs to determine the strength and direction of the relationship between the independent and the dependent variables of the study. Results are depicted in Table 4.4.

Table 4.4: Correlation between Participatory Planning and Performance of Health Centers

	Performance of Health Centers	
Participatory planning	Pearson correlation	.417**
	Significance	.000
	N	92

**Significant at .001

Source: Survey Data

From Table 4.5, results show a Correlation Coefficient, *rho*, of .417 and positive. This implies that there is a strong and positive relationship between the independent variable – participatory planning and the dependent variable - performance of HCs. This means that as citizen's participation in healthcare planning increases, the performance of HCs consequently enhances. Conversely, as citizen's participation in planning HCs activities decreases then performance of HC also decreases. In addition, the results of the two-tailed test show that the two tailed test is significant at .000 less than alpha level, .001 (Alpha, $\alpha = .001 > p = .000$ found in this study; where, p = calculated probability value). The null hypothesis that there is no relationship between participatory planning and performance of HCs is therefore rejected in favour of the researcher's hypothesis that there is a positive relationship between

participatory planning and performance of HCs. This finding depicts that participatory planning positively affects the performance of HCs.

4.4.2.2 Regression Analysis between Participatory Planning and Performance of Health Centres

Regression analysis was run between participatory planning and performance of HCs. The model summary results are depicted in Table 4.5.

Table 4.5: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.417[a]	.174	.165	.60227

a. Predictors: (Constant), Planning

Source: Survey Data

From Table 4.6, the coefficient of determination R – square in this study was found to be .174 while the adjusted R- square is .165. This finding implies participatory planning can explain up to 16.5% of the variations in the dependent variable – performance of HCs leaving the other 83.5% to be explained by other factors other than participatory planning.

The regression coefficients of participatory planning are depicted in Table 4.6.

Table 4.6: Regression Coefficients

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.987	.215		13.907	.000
	Planning	.249	.057	.417	4.353	.000

a. Dependent Variable: Performance

Source: Survey Data

From Table 4.6, the unstandardized regression coefficient of participatory planning was found to be .249 and positive with calculated probability p-value less than alpha ($\alpha = .001 > p = 0.000$; where, p = calculated probability value). This implies that for every one percent increase in involvement of citizen in healthcare planning process the performance of HCs increased by .249 percent. In addition this results are statistically significant at 99 percent level of confidence. This therefore implies that participatory planning are significant predictors of performance of HCs. Every effort geared towards enhancement of performance of HCs should therefore focus on participatory planning.

4.4.3 Participatory Implementation and Performance of HCs

Presented under this section are findings for the effect of participatory implementation on performance of health centers for descriptive and inferential statistics.

Respondents were asked to evaluate statements relating to each of the indicators under participatory implementation in HCs using a five point Likert Scale as follows: Strongly disagree = 1; disagree = 2; not sure = 3; agree = 4 and strongly agree = 5 as indicated in Table 4.7.

Table 4.7: Participatory Implementation

C. Participatory Implementation	**Perception of Respondents (%)**					**Score**	**Deviation**
(i) Availability of HC Services	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Sta. Dev.**
Citizens often have access to information on hc to judge its accuracy	**3.3**	**14.1**	**14.1**	**39.1**	**29.3**	**3.77**	**1.12**
Citizens are involved in (hc) out-reach activities	**7.6**	**16.3**	**23.9**	**28.3**	**23.9**	**3.45**	**1.235**
Citizens have been provided promotional materials (stickers,	**12**	**12**	**23.9**	**30.4**	**21.7**	**3.38**	**1.283**
The representative we have elected participate hc debates	**5.4**	**17.4**	**19.6**	**32.6**	**25**	**3.54**	**1.199**
Elected representatives often consult citizens on hc matters	**3.3**	**12**	**27.2**	**35.9**	**21.7**	**3.61**	**1.058**

Public hearings on hc have often been conducted	**2.2**	**12**	**29.3**	**37**	**19.6**	**3.6**	**1.996**
Citizens input on hc have often been taken into account	**4.3**	**14.1**	**21.7**	**40.2**	**19.6**	**3.28**	**1.092**
Citizens needs are often considered in implementation decisions	**7.6**	**17.4**	**21.7**	**31.5**	**21.7**	**3.42**	**1.225**

Source: Survey Data

From Table 4.7, the majority (68.4%) of respondents agreed that citizens often have access to information on healthcare to judge its accuracy (agree 39.1%; strongly agree 29.3%) with a mean of 3.77 and standard deviation of 1.12. This finding suggests that citizens are empowered with the necessary information to appreciate the activities of the HCs in terms of scope and resources at their disposal. This could enable citizens to demand services based on informed choices. On out-reaches, the majority (52.2%) of respondents agreed that citizens are involved in healthcare out-reach activities (agree 28.3%; strongly agree 23.9%) with a mean of 3.45 and standard deviation of 1.235. This finding suggests that the community has links to healthcare activities at their localities through healthcare out-reach activities. This is one of the strategies to ensure that the community is engaged to obtain information on healthcare that could enhance public health awareness to improve healthcare outcomes that could ultimately enhance the performance of HCs.

On provisional of promotional materials, the majority (51.2%) of respondents agreed that citizens have been provided promotional materials like stickers and healthcare promotion posters (agree 30.4%; strongly agree 21.7%) with a mean of 3.38 and standard deviation of 1.283. This finding suggests that activities to promote good health is undertaken. Health promotion although a software intervention could lead to overall reduction in the cost of healthcare following the maxim, "prevention is better than cure." This means that the limited healthcare budgetary resources can be directed to more critical areas of need to cause impact.

The majority (57.6%) of respondents agreed that representative we have elected participate in healthcare debates and meetings (agree 32.6%; strongly agree 25%) with a mean of 3.54 and standard deviation of 1.199. the implication of this finding is that information sharing has been continuously achieved. This finding suggests that citizens' views are incorporated in healthcare implementation decisions.

In terms of consultation by elected representatives, the majority (56.6%) of respondent agreed that elected representatives often consult citizens on healthcare matters (agree 35.9%; strongly agree 21.7%) with a mean of 3.61 and standard deviation of 1.058. This finding suggests that citizens' views are taken and they are articulated by representatives to HC management for action. The majority (56.6%) of respondent agreed that Public hearings on healthcare have often been conducted (agree 37%; strongly agree 19.6%) with a mean of 3.6 and standard deviation of 1.996. This could provide opportunities for citizens not only to obtain information but above all, to ask tough questions on healthcare matters that affect them. On whether citizens needs have been taken into account, the majority (59.8%) of respondents agree that citizens' input on healthcare have often been taken into account (agree 19.6%; strongly agree 40.2%) with a mean of 3.57 and standard deviation of 1.092. This, therefore, means that citizens' needs are integrated in implementation decisions. The majority (53.2%) of respondents agreed that citizens needs are often considered in implementation decisions (agree 31.5%; strongly agree 21.7%) with a mean of 3.42 and standard deviation of 1.225.

From the responses above, citizens contend that they are involved in implementation of healthcare activities. They obtain information pertaining to implementation of healthcare activities, promotional materials and their needs are considered. This is in consonance with a Key informant who for example in support of this view said,

> "… *when medicines are received from National Medical Stores, local leaders together with the local people living near the health facility are called upon to verify both the type and quantities of drugs and other medical supplies consigned to the health facility to inform them what will be available to them....* (Key Informant Interview).

Opportunities to verify such information is one of the ways citizens can participate not only to obtain information on medical supplies and medicines but also to enable them make informed choices and perhaps reduce resource hemorrhage when they keep an eye to ensure that supplies are not misappropriated by health workers.

Citizens' participation in healthcare implementation decisions have taken many forms, for example in distribution decisions. This assertion is supported by the view in FGD where one said,

> *"In case supplies like mosquito nets, where the consignments are inadequate local citizens are consulted to prioritize as to who should benefit for example pregnant mothers, mothers of mothers new born babies who take the first priorities while the others could wait...*"

The above assertion depicts how practical and assertive citizen participation can benefit the sector. It does not only depict how priorities are set but can also help to reduce suspicion, social tensions and help to achieve rational and justifiable health outcomes that could enhance performance of HCs.

Communication of implementation of HC activities have been done in advance to ensure that citizens are aware. For example when medical supplies are expected to be delivered, out-reach activities are to be undertaken or health camps and clinics are planned to take place in a

particular location, they are communicated through elected representatives, VHWs and through radio announcements. In a FGD one said,

> *'... before a health camps was held in my area, my LC Councilor told us that they were called in a meeting at the HC to decide where they should start the health camp and they (with participation of LCs) decided that they should start from our village..'*

This is another way that implementation decisions are made with indirect participation of citizens through their elected representatives and leaders.

4.4.3.1 Correlation between Participatory Implementation and Performance of Health Centers

Correlations were run between participatory implementation and performance of HCs to determine the strength and direction of the relationship between the independent variable – participatory implementation and the dependent variable- performance of HCs, Table 4.8.

Table 4.8: Correlation between Participatory Implementation and Performance of Health Centers

Participatory Implementation	Pearson Correlation	.582
	Significance	.000
	N	92

Source: Survey Data

From Table 4.8, Correlation coefficient was found to be .582 and positive. This implies that there is a strong and positive relationship between the independent variable – participatory implementation and the dependent variable - performance of HCs. This means that as citizen's participation in healthcare implementation increases, the performance of HCs consequently increases. Conversely, as citizen's participation in implementation of HCs

activities decreases, performance of HCs also decreases. In addition, the results show that the two tailed test is significant at .000 less than alpha level, .001 (Alpha, α = .001 > p =.000 found in this study; where, p = calculated probability value). The null hypothesis that there is no relationship between participatory implementation and performance of HCs is therefore rejected in favour of the researcher's hypothesis that there is a positive relationship between participatory implementation and performance of HCs. This finding depicts that participatory implementation positively affects the performance of HCs.

4.4.3.2 Regression Analysis between Participatory Implementation and Performance of Health Centres

Regression analysis was run between participatory implementation and performance of HCs, the model summary results are depicted in Table 4.9.

Table 4.9: Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.582[a]	.339	.332	.53864

a. Predictors: (Constant), Implementation

Source: Survey Data

From Table 4.9, the coefficient of determination R in this study was found to be .582 while the adjusted R- square is .339. This finding implies that participatory planning can explain up to 33.4% of the variations in the dependent variable – performance of HCs leaving the other 66.6% to other factors other than participatory implementation.

The regression coefficients of participatory implementation are depicted in Table 4.10.

Table 4.10: Regression Coefficients

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.817	.309		5.880	.000
	Implementation	.583	.086	.582	6.798	.000

a. Dependent Variable: Performance

Source: Survey Data

From Table 4.10, the unstandardized beta coefficient was found to be .583 and positive. This implies that for every one percent increase in participation of citizens in healthcare implementation process, healthcare performance increases by .583 percent. In addition, the two-tailed test shows that the calculated probability p-value was found to be less than alpha ($\alpha = .001 > p = 0.000$; where, p = calculated probability value). This implies that for every one percent increase in involvement of citizen in healthcare implementation, the performance of HCs increased by .583 percent. In addition these results are statistically significant at 99 percent level of confidence. This therefore implies that participatory implementation is a significant predictors of performance of HCs. Every effort geared towards enhancement of performance of HCs should therefore focus on participatory implementation.

4.4.4 Participatory Monitoring and Evaluation

Presented under this section are findings for the effect of participatory monitoring and evaluation on performance of health centers for descriptive and inferential statistics.

Respondents were asked to evaluate statements relating to each of the indicators under participatory monitoring and evaluation of HCs using a five point Likert Scale as follows: Strongly disagree = 1; disagree = 2; not sure = 3; agree = 4 and strongly agree = 5 as presented in Table 4.11.

Table 4.11: Participatory Monitoring and Evaluation

Independent variable	**Respondent Perceptions (%)**					**score**	**Deviation**
d) Participatory M&E	S.D = 1	D = 2	N. S =3	A = 4	S. A = 5	Mean	St. dev
Citizens have ever been trained in data collection strategies for M & E	5.4	12	22.8	38	21.7	3.59	1.12
Citizens have often provided information/ opinion in M & E (e.g surveys)	5.4	18.5	26.1	33.7	16.3	3.37	1.13
M & E findings on hc have often been presented to citizens for critique	6.5	21.7	27.2	29.3	15.2	3.25	1.15
Citizens have participated in joint learning on hc	5.4	14.1	37	30.4	13	3.32	1.05
I am aware of joint government-civil society monitoring	6.5	17.4	21.7	34.8	19.6	3.43	1.18
Citizens have often provide views to influence policymakers	6.5	21.7	28.3	28.3	15.2	3.24	1.15
Community partners have been involved in M & E	9.8	15.2	25	33.7	16.3	3.32	1.2
Citizens have ever responded to surveys (studies e.g report cards)on hc	13	18.5	18.5	27.2	22.8	3.28	1.35

Source: Survey Data

Results in Table 4.11, show that the majority (59.7%) of respondents agreed that Citizens have ever been trained in data collection strategies for monitoring and evaluation (agree 38%; strongly agree 21.7%) with a mean of 3.59 and standard deviation of 1.12. The implications of these findings are that citizens need to be made to appreciate the importance of their perceptions towards healthcare that is provided to them thus they should be made aware how their views can be collected especially in formal studies. This finding means that citizens are aware that their views matter and could change the ways things are done.

In terms of provision of opinions, the majority (50%) of respondent agreed that citizens have often provided information/ opinion in monitoring and evaluation studies (for example, surveys) (agree 33.7%; strongly agree 16.3%) with a mean of 3.37 and standard deviation of

1.13. This implies that citizens' views are compiled in reports upon which recommendations have been made. The majority (44.5%) of respondents agreed that monitoring and evaluation findings on healthcare have often been presented to citizens for critique (agree 29.3%; strongly agree 15.2%) with a mean of 3.25 and standard deviation of 1.15. The implication of this finding is that citizens obtain not only feed-back on the views they present but also on how their views have been perceived and claims made about what public deliveries have been made to them in order for them to react to.

On participation in joint learning, the majority (43.4%) of respondents agreed that citizens have participated in joint learning on healthcare (agree 30.45; strongly agree 13%) with a mean of 3.32 and standard deviation of 1.05. This finding suggests that awareness and sensitization on healthcare outcomes and information is provided to citizens. In terms of joint monitoring, the majority (54.4%) of respondent agreed that I am aware of joint government-civil society monitoring (agree 34.8%; strongly agree 19.6%) with a mean of 3.43 and standard deviation of 1.18. The implication of this study is that the outcome of such evaluations are valid and verifiable as citizens interests are taken care by CSOs in such studies. This means such reports are verifiable and thus valid. The majority (43.5%) of respondent agreed that Citizens have often provide views to influence policymakers (agree 28.3%; strongly agree 15.2%) with a mean of 3.32 and standard deviation of 1.2. This finding suggests that citizen participation has been recognized as being important in informing public policies which means that public policies on healthcare prioritizes citizens' needs.

On citizen partners' involvement, the majority (50.0%) of respondents agreed that community partners have been involved in monitoring and evaluation (agree 33.7%; strongly agree 16.3%) with a mean of 3.32 and standard deviation of 1.2. In terms citizens response to surveys, the majority (50.0%) of respondent agreed Citizens have ever responded to surveys

(studies e.g report cards) on healthcare (agree 27.2% ; strongly agree 22.8%) with a mean of 3.28 and standard deviation of 1.35. These findings suggest that citizens' views are taken into account. This study is one of such that intends to advance citizens needs in terms of recommendations that will be brought to the attention of each HC management committees and the Public Health Officer at the municipal level.

From the above responses, citizens participate in monitoring and evaluation activities when they respond to surveys, while civil societies conduct joint monitoring of healthcare activities with government. This position was supported by the views of a key informants that,

> *"... the local government provided opportunities for CSOs and NGOs in monitoring and evaluation activities on healthcare matters. ...We conduct joint monitoring and listen to citizens views. ...we follow up what citizens have reported through their representatives as we want to be transparent in whatever we do.* (Key Informant).

Monitoring and evaluation is based on base line information. Respondents in this study concur under planning and implementation sections that planning information is provided to them while supplies and medicine consignments, for example, are disclosed to them which provides a basis for monitoring and evaluation. These are important parameters that empower citizens in monitoring and evaluation processes. Radio announcements have also reported to have been run, asking the public to report to their leaders, situations of stick-outs of essential medicines when they fail to receive them at the health facilities to enable leaders to verify and demand for their replenishment. These are examples of monitoring activities in which citizens directly participate.

4.4.4.1 Correlation between Participatory Monitoring and Evaluation and Performance of Health Centers

Correlations were run between participatory monitoring and evaluation and performance of HCs to determine the strength and direction of the relationship between the independent variable – participatory monitoring and evaluation and the dependent variable- performance of HCs. Results are depicted in Table 4.12.

Table 4.12: Correlation between Participatory monitoring and Evaluation and Performance of Health Centers

	Pearson Correlation	0.302
Participatory monitoring and evaluation	Significance	0.003
	N	92

Source: Survey Data

From Table 4.12, Correlation coefficient was found to be .302 and positive. This implies that there is a moderately strong and positive relationship between the independent variable – participatory monitoring and evaluation and the dependent variable - performance of HCs. This means that as citizen's participation in healthcare monitoring and evaluation increases, the performance of HCs consequently increases. Conversely, as citizen's participation in monitoring and evaluation of HCs activities decreases then performance of HC also decreases. In addition, the results show that the two tailed test is significant at .003 less than alpha level, .005 (Alpha, $\alpha = .005 > p = .003$ found in this study; where, p = calculated probability value).

The null hypothesis that there is no relationship between participatory monitoring and evaluation and performance of HCs is, therefore, hereby rejected in favour of the researcher's hypothesis that participatory monitoring and evaluation is significantly positively related to

the performance of HCs. This study depicts that participatory monitoring and evaluation positively affects performance of HCs,

4.4.4.2 Regression Analysis between Participatory Implementation and Performance of Health Centres

Regression analysis was run between participatory implementation and performance of HCs, the model summary results are depicted in Table 4.13.

Table 4.13: Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.302[a]	.091	.081	.63170

a. Predictors: (Constant), Monitor evaluate Implementation

Source: Survey Data

From Table 4.13, the coefficient of determination R in this study was found to be .0.91 while the adjusted R- square is .081. This finding implies participatory planning can explain up to 8.1 percent of the variations in the dependent variable – performance of HCs leaving the other 91.9 percent to other factors other than participatory monitoring and evaluation.

The regression coefficients are depicted in Table 4.14.

Table 4.14: Regression Coefficients

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.926	.325		9.010	.000
	Monitor evaluate Implementation	.285	.095	.302	3.005	.003

Source: Survey Data

From Table 4.14, the unstandardized beta coefficient was found to be .285 and positive. This implies that for every one percent increase in participation of citizens in healthcare monitoring and evaluation process, healthcare performance increases by .285 percent. In addition, the two-tailed test shows that the calculated probability p-value was found to be less than alpha ($\alpha = .005 > p = 0.003$; where, p = calculated probability value). This implies that for every one percent increase in involvement of citizens in healthcare monitoring and evaluation, the performance of HCs increased by .285 percent. In addition these results are statistically significant at 95 percent level of confidence. This therefore means that participatory monitoring and evaluation is a significant predictor of performance of HCs. Every effort geared towards enhancement of performance of HCs should therefore focus on participatory monitoring and evaluation.

CHAPTER FIVE

SUMMARY, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study examined the effect of citizen participation on the performance of selected HCs in Nansana Municipality in Wakiso district in Uganda. The chapter presents a summary of the findings of the study, discusses the results and draws conclusions from the study and recommends ways in which the performance of HCs could be improved.

5.2 Summary of Findings

Presented under this section is a summary of findings by the study themes;

5.2.1 Participatory Planning and Performance of Health Centres

This study found a strong, positive and significant relationship between participatory planning and performance of HCs. The implications of this finding is that as citizen's participation in healthcare planning deepens, the performance of HCs consequently increases. Conversely, when citizens' participation in healthcare planning process decreases the performance of HC consequently reduces. Every effort geared towards enhancement of performance of HCs should therefore focus on increasing citizen participation in healthcare planning process.

5.2.2 Participatory Implementation and Performance of Health Centres

This study found a very strong, positive and significant relationship between participatory implementation and performance of HCs. The implication of this finding is that as citizen participation in healthcare implementation deepens, the performance of HCs consequently increases. Conversely, when citizen participation in healthcare implementation decreases, the performance of HCs consequently reduces. Efforts geared towards enhancement of

performance of HCs should therefore focus on deepening participation of citizens in healthcare implementation process.

5.2.3 Participatory Monitoring and Evaluation and Performance of Health Centres

This study found a moderately strong, positive and significant relationship between participatory monitoring and evaluation and performance of HCs. The implication of this finding is that as citizen participation in monitoring and evaluation activities increases, the performance of HCs also increases. Conversely as citizen participation in monitoring and evaluation efforts decreases, the performance of HC also decreases. Efforts geared towards enhancement of performance of HCs should therefore focus on deepening participation of citizens in monitoring and evaluation of healthcare activities.

5.3 Discussions

Following from the summary of findings, presented in this section is a discussion which relates literature to the study findings by theme.

5.3.1 Participatory Planning and Performance of Health Centers

The study established a strong, positive significant relationship between participatory planning and performance of HCs. This finding is consistent with WHO (2002); Urbinati and Warren (2008); and Handley and Howell-Moroney (2010) where similar findings were replicated in separate studies in different public facilities. These findings underscore the importance of participation of citizens in healthcare planning and consequently on the performance of HCs.

The strong relationship between participatory planning and performance of HCs found in this study could perhaps be attributed to the belief that citizens could better identify and articulate

their own healthcare needs and set their priorities. This therefore means that when their participation is meaningful in the planning process, then the healthcare outcomes that they expect are likely to be realized. It could also enable them to articulately provide the necessary planning information and suggest innovative alternative approaches that could lead to more efficient allocation of resources to effectively address their real local healthcare needs as suggested by Lu and Xue, (20110); Cavric, (2011); and Lukensmeyer, Goldman and Stern (2011). In this study it was found that citizen's inputs have often been taken into account in making healthcare decisions. This finding is also supported by the principle that those who are affected by a particular decision should meaningfully participate in their making (Urbinati & Warren, 2008) which again reinforces the study findings from a logical perspective.

In the practical world, many challenges however, tend to confront the planning process due to absence of sufficient information upon which healthcare plans could be based. These challenges could however, be resolved when diverse individuals are engaged to bring their different perspectives, knowledge and information that could improve delivery of public services like healthcare including to the disadvantaged (Sirianni, 2009; Batley & Rose, 2011; Pandeya 2015) that could ultimately enhance the performance of HCs. In this study, it was found that citizens have ever given their views on healthcare to management which were considered and incorporated in the planning process. Citizens were also provided opportunities to attend meetings to discuss healthcare issues which could have led to the success of such plans which in turn has led to the high performance of the HCs covered in this study as the findings depict consistent with views of Batley and Rose (2011) that different perspectives from diverse sources lead to better quality of plans.

Although the merits of participatory planning have long been recognized, public officials and community leaders have not been conversant with participatory methodologies to facilitate

effective citizen participation as suggested by Yang and Pandey (2011); Bryson et al. (2013); and Marzuki (2015). To realize their desires, citizens should be provided information and more understanding on public participation processes to enable them participate in planning of their future (Hornbein & King, 2012; Neshkova et al, 2012). This study found that community partners have been provided information and tools required to identify citizens' healthcare needs and priorities. This finding suggests that community partners have been a mouth piece through which citizen's desires have been articulated. This approach is one way of citizen participation in the planning process that could enhance performance of HCs. The approach could also avert fears that citizen involvement is time consuming, costly, could lead to loss of control in the planning process and liable to advancement of individual self-interests against broader public interest (Sainsbury, 2004; Ebdon & Franklin, 2004; Heikkila & Issett, 2007; Simonsen & Feldman, 2008).

5.3.2 Participatory Implementation and Performance of Health Centres

The study revealed a strong, positive and statistically significant relationship between participatory planning and performance of HCs. This finding could be explained by the belief that participation of citizens in implementation of healthcare activities could lead to enhanced rational decision-making on matters that affect citizens' lives (UN, 2008; Neshkova & Guo, 2011; Marzuki, 2015). This notion is premised on the presumption that citizens know what they want and thus would not like to be directed on what their needs ought to be or how healthcare services should be delivered which would ultimately be in disharmony with citizens' real needs and priorities in terms of healthcare implementation decisions which could perceptually diminish the performance of HCs.

Provision of public services should be done in a fair manner and received equitably by recipient citizens. In this regard, participation of citizens in implementation of healthcare

activities could also produce inclusive development and equity-based decision-making (Bell, Adams and Brown, 2002; Venugopal & Yilmaz, 2009; Mohanty, 2010), and facilitates extension of improved services (UN, 2008; UNDP, 1993) and could produce "outcomes that favor the poor and disadvantaged" (UN, 2008, p.23). Citizen participation in implementation of LG services like healthcare, for example, could also improve the performance of such public institutions like HCs as it could minimize corruption as available public resources would have been disclosed to them. This could also facilitate a more effective monitoring of implementation activities by citizens or their representatives (Porter & Onyach-Olaa, 2001; Muriu, 2014; Neshkova et al., 2012). This study found that citizens often have access to information on healthcare to judge its accuracy. This finding suggests that citizens are empowered with the necessary information to appreciate the activities of the HCs in terms of scope and resources at their disposal. This could enable citizens to demand services based on informed choices which perhaps made citizens to perceive performance of HCs covered in this study high consistent with the belief that effective citizen's participation results into inclusive development and equity-based decision-making.

Civil Society Organizations (CSOs) have increasingly been promoted as the organizational alternative to people-centered, inclusive and participatory development' (Devas et al., 2001). They have been lauded to offer organized force with which LGs can engage, for example, in informal lobbying, negotiations and advocacy for change (Devas et al., 2001) as a form of citizen participation espoused in Theories of Representative Democracy (Samah & Aref, 2011). Studies have however shown that CSOs have often not been strong in engaging with LGs (Blair, 2000). This has been partly attributed to the functional nature CSOs and inadequate government support as well as weak links with community leaders, inadequate advocacy experience and low organizational capacity for accessing the less privileged (Blair, 2000; Devas et al., 2001). Key informant interviews with NGOs working in the health sector

conceded that they help advance citizens healthcare needs. Some of them provide complementary healthcare services at the HC like an international NGO working in the municipality - Marie Stopes.

The traditional and conventional means of direct citizen participation in implementation of public services have taken the form of: serving on juries, attending public hearings, being part of commissions or task forces, responding to questionnaires or surveys, or filing complaints. Meanwhile, more innovative means of direct participation include large groups coming together to deliberate on pertinent issues that affect citizens to direct government attention (Roberts, 2004; Easterly, 2010). This study found that public hearings on healthcare have often been conducted. Additionally citizens have been represented on HC management boards by elected representatives. They participate in management meetings where implementation decisions are also made and follow implementation activities of the HC in this study. This is a form of indirect citizen participation espoused by Easterly (2010).

Mechanisms of participatory implementation of public services include establishment of political quotas for minority groups to ensure their direct involvement in for example health sector management (Banerjee, Deaton & Duflo 2004; Kremer & Vermeesh 2005) in addition to (other) elected representation on governance/ management boards. This study found that representatives we have elected participate in healthcare debates and meetings. This is a meaningful strategy of citizen participation through elected representatives. The study also found that elected representatives often consult citizens on healthcare matters to collect and represent their views in healthcare management meetings.

In order to enhance the quality and legality of public decisions, public involvement should include innovative approaches like citizen suits, public hearings, comments, (Sayce, 2013;

NRC, 2008). Such approaches could complement the roles of elected leaders in planning for public services. In this study it was found that community partners have been provided information and tools required to identify citizen's needs and to establish their priorities as a collaborative approach. In this study public hearings were also found to be conducted on healthcare issues in the three HCs covered in this study. This initiative was spear-headed by the political leadership in the Municipal Council.

5.3.3 Participatory Monitoring and Evaluation and Performance of Health Centres

This study found a moderately strong relationship between participatory monitoring and evaluation and performance of HCs. In the context of delivering services, answerability can be applied bottom-up by NGOs, CSOs, media and the citizens (Griffin et al., 2010). To effectively perform this, citizens need to be informed personally and communally, about their entitlements, amenities and gains they are mandated to obtain, the quality standards they should anticipate, and remedial measures they can apply when things go wrong (Ringold, Holla, Kaziol, & Sranivasan, 2012). In accordance with the foregoing, this study found that that monitoring and evaluation findings on healthcare have often been presented to citizens. This has provided citizens opportunities to critique and /or ask question on matters that concerned them in accordance with representative Democracy Theory.

Civil society and NGO have for decades been citizens-government-partners in development. They have represented citizens and helped advance citizens interests on matters that concern them (Griffin et al., 2010). In this vain, CSOs and NGOs have been involved in monitoring and evaluation of the performance of government institutions like HCs at local government level. They are therefore, important players that provide information to citizens on the status of performance of government institutions like HCs. The kind of information they usually provide gain acceptance as citizens consider them impartial and trustworthy. In this study, it

was found that joint government-civil society M & E of implementation of healthcare activities have been carried out. Community partners have also been involved in M & E of healthcare activities while citizens have also ever responded to surveys on healthcare provision. This form of partnership helped advance citizens interests on matters that concern them (Griffin et al., 2010).

The purpose of participatory M & E is to ensure that citizens track the performance of service providers and ultimately the HCs. The performance of HCs need to be closely monitored against the original directives (Camargo & Eelco, 2010). The pressure to concentrate on implementation processes and outcomes in delivery of public services could reinforce the importance linked to measurable results which demand for a robust function of citizens in monitoring and evaluation of healthcare implementation activities to guarantee that planned objectives are attained (Ringold, Holla, Kaziol, & Sranivasan, 2012). In this process, leaders are made to provide financial, physical and social accountability where public healthcare resource are confirmed to have been used as planned and where abuse could also be identified. This study found that M & E of activities of the HCs have been carried out at the health facilities by CSO, NGOs and the local people, reports and recommendation of findings therein made to the health management committees for action.

In the HCs, for example, when consignments of supplies and medicines are to be received, local leaders and the local people are invited to witness such deliveries to enable them effectively monitor the use of such medical inventories. Radio programmes have also been run to alert the populace to report stock outs of essential medicines in HCs. This is an appropriate citizen-based monitoring system so that necessary actions like ensuring that the stocks are replenished in case there are delays to rid HCs of unnecessary shortage of supplies. Shortage of medicines for example, lead to people with certain medical conditions to become

resistant to treatment with certain medicines like antibiotics when the required doses are not administered.

5.4 Conclusions

Based on the findings of this study, the following conclusions are hereby drawn.

5.4.1 Participatory Planning and Performance of Health Centres

This study established a positive relationship between participatory planning and performance of HCs. Planning provides a road-map for any proposed public service activity like healthcare. It is also to keep citizens informed, but also to instill public trust and to set meaningful priorities that reflect the real needs and desires of citizens in the undertakings. In order to achieve enhanced HC performance, citizens should be made to meaningfully participate in the entire healthcare planning process.

5.4.2 Participatory Implementation and Performance of Health Centres

This study established a positive relationship between participatory implementation and performance of HCs. Implementation of healthcare activities translates plans into action. Citizen participation, through direct participation and indirectly through elected representatives or through CSO/ NGO partnership provides opportunities to deliver the healthcare activities that citizens truly need. To enhance the performance of HCs, citizen participation in healthcare implementation has been found to be very crucial.

5.4.3 Participatory Monitoring and Evaluation and Performance of Health Centres

This study established a positive relationship between citizen participation in monitoring and evaluation and the performance of HCs. Participatory monitoring and evaluation provides

opportunities to track the progress of implementation of healthcare activities and to ensure as much as possible that the activities progress as planned to achieve set objectives and targets. These activities will largely be verified when participatory approaches are applied to reduce incidences of bias and self-interest. All efforts to achieve enhanced performance of HCs have been found to be based on meaningful participation of citizens in monitoring and evaluation of healthcare activities.

5.5 Recommendations

In view of the conclusions drawn, the following recommendations are hereby made.

5.5.1 Participatory Planning and Performance of Health centers

- The MoH, CSOs and NGOs should develop the capacity of HC staff in participatory planning approaches to healthcare service delivery.
- Health Centre management committees should mainstream participatory planning as a deliberate policy in delivery of healthcare services.
- The Municipal Public Health officer (PHO), CSOs and NGOs should increase citizen awareness and sensitization dives in citizen involvement in healthcare planning.

5.5.2 Participatory Implementation and Performance of Health Centres

- The MoH and the PHO, CSOs and NGOs should develop the capacity of HC staff in participatory implementation methodologies.
- The MOH and PHO should mainstream participatory implementation approaches in healthcare service delivery.
- The MoH, PHO, HCs should create awareness and sensitize citizens in participatory implementation of healthcare activities.

- The HC management committees should strengthen community out-reach and provide healthcare promotional materials as a form of awareness creation.

5.5.3 Participatory Monitoring and Evaluation and Performance of Health Centres

- The MOH, PHO, CSOs and NGOs should develop the capacity of HC staff in participatory monitoring and evaluation methodologies.
- The MoH, PHO, HCs should mainstream participatory monitoring and evaluation approaches in healthcare service delivery.
- The MoH, PHO, HCs should create awareness and sensitize citizens in participatory monitoring and evaluation.
- Civil Society Organizations should produce routine scorecards, arrange public hearings and barrazas.

5.6 Limitations to the Study

This study was faced with a number of limitations. Some key informants were not available during the time of data collection. This was, however, overcome by substituting them with their immediate subordinate officers. It was also difficult to obtain a list of patients as most of them were out-patients save for those attending maternity clinic who were often in need of immediate medical attention and therefore could not be interviewed. As a result convenience sampling had to be adopted for patients and care givers posing limitations in terms of inability to adopt probability-based respondent selection strategies.

5.7 Contribution of the Study to Existing Body of Knowledge

This study provided opportunities to examine citizen participation and performance of HCs in Nansana Municipality, wakiso district. The contribution of this study is that it has provided new information on this subject matter especially in the study area where no such study has

ever been systematically carried out. Additionally, the minimal exertions to assess citizen participation-performance nexus has offered mixed proof that required a study like this one which was context specific.

5.8 Areas for Further Research

This study was generic and did not specifically focus on any specific healthcare intervention. It is possible that whereas in general terms, citizens were found to be involved in planning, implementation and monitoring and evaluation of healthcare activities, it is possible that participation could only be achievable in some form of healthcare and not others. It is recommended that further studies be carried out on specific interventions like malaria control.

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APPENDIX I: QUESTIONNAIRE: Administered to HC staff and Health Care Community Members

This questionnaire shall be used by the researcher to obtain information from HC management committees and HC TMT.

Background Information ***(please tick appropriate box in each case)***

1. Gender: 1. 1 Male ☐ 1. **2**. Female ☐
2. Please indicate your age class.2.1. 20 - 30yrs ☐ 2.**2**. 31 -40 ☐ 2.3 41-50 ☐
   2.4 Above 50 ☐
3. Position in organization (*tick as appropriate).*

3.1 Senior management ☐ 3.2. Middle manag't ☐ 3. 3. Supervisory ☐
3. 4. Operational level ☐

4. Highest level of education: 4.1. Secondary ☐ 4.2. Diploma ☐ 4. 3. Degree ☐
   4.4Postgraduate ☐
5. Please indicate the number of years you have worked for the health centre (*tick as appropriate*).

   5.1 Less than 2yrs ☐ 5.**2.** 2-5yrs ☐ 5.**3.** Up to 10yrs ☐ 5.**4**. 10 ☐
above 10yrs

6. Please indicate the Department (section) in which you work (*tic as appropriate*).
7. Finance ☐ 6.**2.** Admin ☐ 6.**3.Clinic** ☐ 6.**4**.Lab ☐

   6. 5. Audit ☐ 6.8 other (specify) ☐

This questionnaire is designed according to the objectives of the study.

Please indicate your level of agreement to each of the following statements specifically with respect to BRAC UGANDA (using 1 = strongly disagree, (S.D); 2 = agree (A); 3 = not sure (N.S); 4 = agree (A); 5 = strongly agree (S.A). Please tick ***ONLY ONE BOX*** *in each case as appropriate.*

Healthcare workers questionnaire					
a) Performance of Health Cate Centres (Dependent variable)	**S.D = 1**	**D = 2**	**N. S =3**	**A = 4**	**S. A = 5**
(i) Available healthcare services					
Hc services required by patients are available					
Hc services required by patients are provided					
Hc services are accessible to patients					
(ii) Responsiveness to citizen's needs					
patients hc needs are often taken into account					
The quality of hc services address patients' needs					
patients hc expectations are often met					
patients are satisfied with hc services they receive					
(iii) Fairness & Equity					
HC services are provided to patients without discrimination (e.g status)					
HC services are provided to all in need					

Different hc services are evenly provided to those that need them					
b) Participatory planning (Independent variable)	**S.D = 1**	**D = 2**	**N. S =3**	**A = 4**	**S. A = 5**
Patients get access to information about HC (plans)					
Citizens are provided opportunities to I give views on hC to management					
Citizens views are considered in the planning process					
Citizens are provided opportunity to attend meetings to discuss hc issues					
Citizens have often participated in obtaining information on hc					
Citizens hc priorities are considered for action					
Citizens inputs have often been taken in making healthcare decisions					
Community partners have been provided information and tools required to identify needs, set priorities					
c) Participatory implementation (Independent variable)	S.D = 1	D = 2	N. S =3	A = 4	S. A = 5
Citizens often have access to information on hc to judge its accuracy					
Citizens are involved in (hc) out-reach activities					
Citizens have been provided promotional materials (stickers, T-shirts, badges, etc)					
The candidate I have elected has ever participated in hc debates					
Elected representatives often consult citizens on hc matters					
Public hearings on hc have often been conducted					
Citizens input on hc have often been taken into account					
Citizens needs are often considered in implementation decisions					
d) Participatory M&E (Independent variable)	S.D = 1	D = 2	N. S =3	A = 4	S. A = 5
Citizens have ever been trained in data collection strategies for M & E					
Citizens have often provided information/ opinion in M & E (e.g surveys)					
M & E findings on hc have often been presented to citizens for critique					
Citizens have participated in joint learning on hc					
I am aware of joint government-civil society monitoring					
Citizens have often provide views to influence policymakers					
Community partners have been involved in M & E					
Citizens have ever responded to surveys (studies e.g citizen report cards)on hc					

APPENDIX II: QUESTIONNAIRES: Administered to patients/ care givers

A. Background Information (please tick as appropriate)

1. Gender: 1. 1 Male ☐ 1. 2. Female ☐

2. Please indicate your age……………………………

3. Please indicate your level of education 1. Primary 2. Secondary 3. Certificate 4. Diploma 5. Degree 6. Post-graduate

This questionnaire is designed according to the objectives of the study.

*Please indicate your level of agreement to each of the following statements specifically with respect to BRAC UGANDA (using 1 = strongly disagree, (S.D); 2 = agree (A); 3 = not sure (N.S); 4 = agree (A); 5 = strongly agree (S.A). Please tick **ONLY ONE BOX** in each case as appropriate.*

Patients' questionnaire					
a) Performance of Health Cate Centers (Dependent variable)	**S.D = 1**	**D = 2**	**N. S =3**	**A = 4**	**S. A = 5**
(i) Available healthcare services					
Hc services I require are available					
Hc services I require are provided					
Hc services are accessible to me					
(ii) Responsiveness to citizen's needs					
My hc needs are often taken into account					
The quality of hc services address patients' needs					
Patients hc expectations are often met					
patients are satisfied with hc services they receive					
(iii) Fairness & Equity					
HC services are provided to patients without discrimination (e.g status)					
HC services are provided to all in need					
Different hc services are evenly provided to those that need them					
b) Participatory planning (Independent variable)	**S.D = 1**	**D = 2**	**N. S =3**	**A = 4**	**S. A = 5**
Patients get access to information about HC (plans)					
Citizens are provided opportunities to I give views on hC to management					
Citizens views are considered in the planning process					
Citizens are provided opportunity to attend meetings to discuss hc issues					
Citizens have often participated in obtaining information on hc					
Citizens hc priorities are considered for action					
Citizens inputs have often been taken in making healthcare decisions					
Community partners have been provided information and tools required to identify needs, set priorities					
c) Participatory implementation (Independent variable)	S.D = 1	D = 2	N. S =3	A = 4	S. A = 5
Citizens often have access to information on hc to judge its accuracy					
Citizens are involved in (hc) out-reach activities					
Citizens have been provided promotional materials (stickers, T-shirts, badges, etc)					
The candidate I have elected has ever participated in hc debates					

Elected representatives often consult citizens on hc matters					
Public hearings on hc have often been conducted					
Citizens input on hc have often been taken into account					
Citizens needs are often considered in implementation decisions					
d) Participatory M&E (Independent variable)	S.D = 1	D = 2	N. S =3	A = 4	S. A = 5
Citizens have ever been trained in data collection strategies for M & E					
Citizens have often provided information/ opinion in M & E (e.g surveys)					
M & E findings on hc have often been presented to citizens for critique					
Citizens have participated in joint learning on hc					
I am aware of joint government-civil society monitoring					
Citizens have often provide views to influence policymakers					
Community partners have been involved in M & E					
Citizens have ever responded to surveys (studies e.g report cards)on hc					

APPENDIX III: INTERVIEW GUIDE

The interview Guide is also designed as per the objectives of this study and it will be used to collect data from CSOs (management) and Clinical / medical officers.

SECTION A

Participatory planning on the performance of Nansolo, Nankuule and Nabweru HCs.

1. How are Citizen's needs identified?
2. How are Citizen's need prioritized?

SECTION B

Participatory implementation on the performance of HCs.

1. How do citizens participate in implementation of hc decisions?
2. How do citizens participate in hc decision-making?

SECTION C

Participatory M&E on the performance of HCs.

1. How are citizens involved to focus to meet objectives?
2. How are citizens involved in ensuring that resources for hc are efficiently utilized?

APPENDIX IV: FOCUS GROUP DISSCUSION GUIDE

This instrument is designed in a manner that shall help the researcher to collect data from the nurses and patients in the health center.

SECTION A

Participatory planning on the performance of HCs.

Do citizens get access to information about HC (plans)?

Are citizens provided with opportunities to give views on hc to management?

Are Citizens' inputs often taken in making healthcare decisions?

SECTION B

Participatory implementation on the performance of HCs.

Do citizens often have access to information on hc to judge its accuracy?

Are citizens involved in (hc) out-reach activities?

Are citizens' needs often considered in implementation decisions?

SECTION C

Participatory M&E on the Performance of HCs.

Have citizens ever been trained in data collection strategies for M & E?

Are M & E findings often been presented to citizens for critique?

Are community partners always involved in M & E?

Are citizens involved in M & E to ensure efficient resource utilization?

Have citizens ever responded to surveys (studies e.g. citizen report cards) on hc?

APPENDIX V: DOCUMENTARY REVIEW CHECKLIST

This tool is designed to review several documents related to the phenomenon under investigation. The documents to be reviewed include:

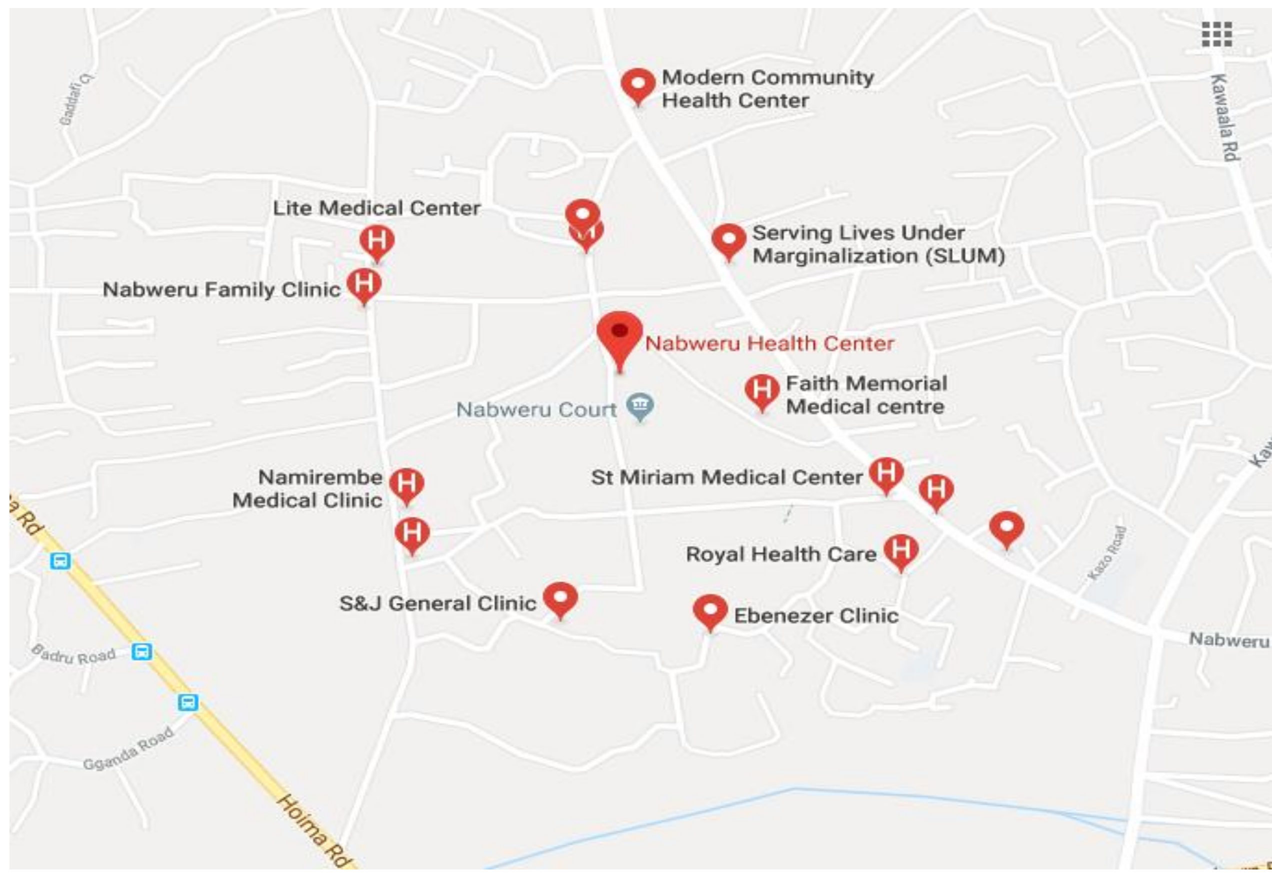
District Quarterly Health reports

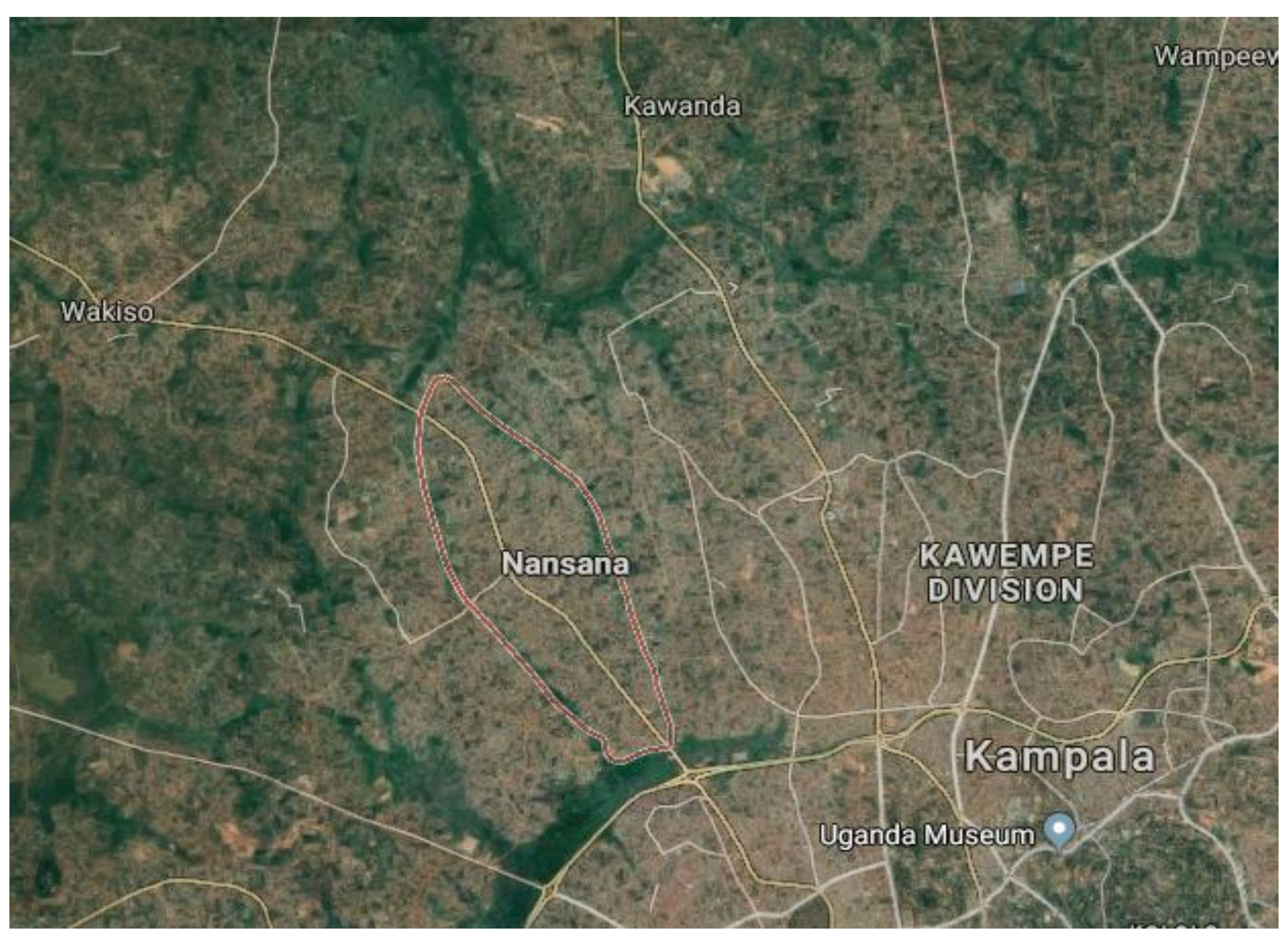
District Annual health performance Reports

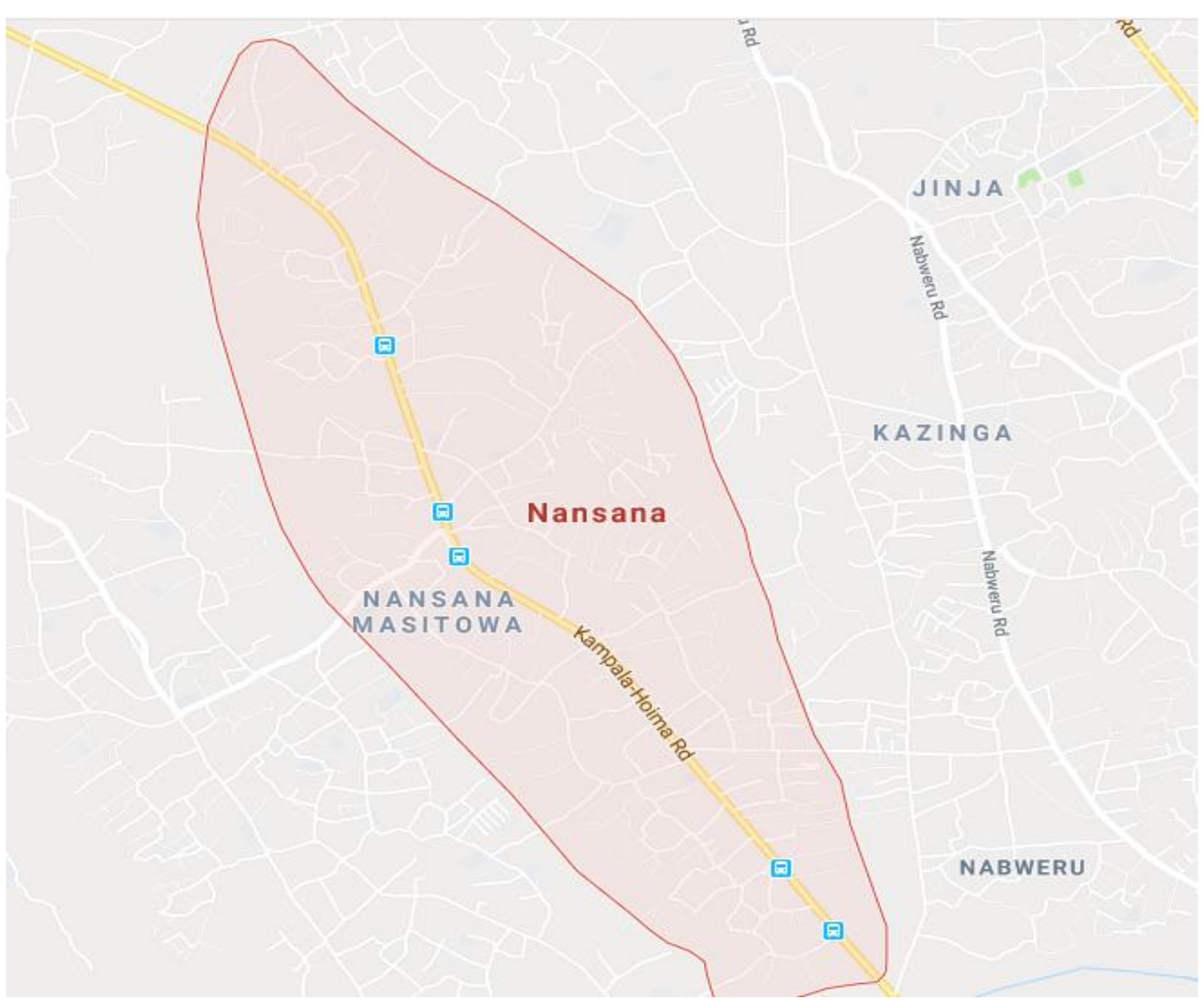
Journals Published about Health

Articles Published about Health

APPENDIX VI: MAPS SHOWING NANSANA MC AND SELECTED HCs




Kawanda
Wakiso
Nansana
KAWEMPE
DIVISION
Kampala
Uganda Museum


JINJA
Nabweru Rd
KAZINGA
Nansana
NANSANA
MASITOWA
Kampala-Hoima Rd
Nabweru Rd
NABWERU

APPENDIX VII: INTRODUCTORY LETTERS

UGANDA MANAGEMENT INSTITUTE

Telephones: 256-41-4259722 /4223748 /4346620
256-31-2265138 /39 /40
256-75-2259722
Telefax: 256-41-4259581 /314
E-mail: admin@umi.ac.ug

Plot 44-52, Jinja Road
P.O. Box 20131
Kampala, Uganda
Website: http://www.umi.ac.ug

Your Ref:

Our Ref: G/35

12th October, 2018

TO WHOM IT MAY CONCERN

MASTERS IN PUBLIC ADMINISTRATION DEGREE

Mr. Albert Collins Kyeyune is a student of the Masters in Public Administration of Uganda Management Institute 15th Intake 2016/2017, **Reg. Number 16/MPA/KLA/WKD/0027.**

The purpose of this letter is to formally request you to allow this participant to access any information in your custody/organization, which is relevant to his research.

His Research Topic is: ***Citizen Participation and Performance of Health Centres in Wakiso District, Uganda: A case of Selected Health Centres in Nansana Municipality".***

Yours Sincerely,

Stella Kyohairwe (PhD)
HEAD, POLITICAL AND ADMINISTRATIVE SCIENCE

UGANDA MANAGEMENT INSTITUTE

Telephones: 256-41-4259722 /4223748 /4346620
256-31-2265138 /39 /40
256-75-2259722
Telefax: 256-41-4259581 /314
E-mail: admin@umi.ac.ug

Plot 44-52, Jinja Road
P.O. Box 20131
Kampala, Uganda
Website: http://www.umi.ac.ug

Your Ref:

Our Ref: G/35

12th October, 2018

Mr. Albert Collins Kyeyune
16/MPA/KLA/WKD/0027

Dear Mr. Kyeyune,

FIELD RESEARCH

Following a successful defense of your proposal before a panel of Masters Defense Committee and the inclusion of suggested comments, I wish to recommend you to proceed for fieldwork.

Please note that the previous chapters 1, 2 and 3 will need to be continuously improved and updated as you progress in your research work.

Wishing you the best in the field.

Yours Sincerely

Stella Kyohairwe (PhD)
HEAD, POLITICAL AND ADMINISTRATIVE SCIENCE

October 18th, 2018

The Town Clerk, Nansana Municipal Council

NANSANA MUNICIPALITY
19 OCT 2018
RECEIVED

Dear Sir/Madam,

RE: **LETTER OF INTRODUCTION/CLEARANCE**

I am **Albert Collins Kyeyune**, a student undertaking a masters of Public Administration at Uganda Management Institute (UMI). I am currently preparing to undertake my research which is a requirement for the award of the degree. The research is entitled, **Citizen Participation and performance of Health Centers in Nansana Municipality."** I would like to carry out this study at **Nakuule Health Centre II, Nabweru Health Centre III and Nansolo Health Centre II** to enable me meet the requirements of my course. This is to humbly seek for your clearance to enable me swiftly commence the study as planned.

I would like to guarantee that my research is purely for academic purposes and flows from public health and it will not in any way prejudice/compromise the plans of the municipality as the findings will only be used as per the proposal attached. I would also like to stretch that having grown up from Nansana West 1 Zone, I was conscious when choosing my own area as my area of study.

I thank in advance for your swift and positive response.

Attached hereto is a letter of introduction from UMI and my proposal.

Yours Faithfully,

Albert Collins Kyeyune
Student of UMI
0776-384279/0702-384279

C.C. Head Public Health, Nansana Municipality
Encl: Research Proposal
Letter of Introduction from UMI.

NANSANA MUNICIPAL COUNCIL

Office of the Clerk
P.O. Box 7218, Kampala Uganda, Tel: +256-752647404
Email: Nansanamc@gmail.com /Website:www.nansana.go.ug

REF: CRM 222/1 19th October, 2018

The In charge,
Nabweru Health Centre III

RE: LETTER OF INTRODUCTION – ALBERT COLLINS KYEYUNE

This is to introduce to you the bearer of this letter a student at Uganda Management Institute (UMI), pursuing a Masters Degree in Public Administration, undertaking an academic research on the topic; **"Citizen Participation and Performance of Health Centres in Wakiso District, Uganda: A case of selected Health Centres in Nansana Municipality"**

Please accord him the necessary assistance required.

Thanks

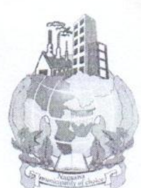
MUNICIPAL TOWN CLERK
19 OCT 2018
NANSANA MUNICIPAL COUNCIL
P.O. BOX 7218, KAMPALA

Daniel Christopher Kawesi
Town Clerk

Copy to;
Her Worship the Mayor – Nansana Municipal Council
Municipal Health Officer – Nansana Municipal Council

NANSANA MUNICIPAL COUNCIL

Office of the Clerk
P.O. Box 7218, Kampala Uganda, Tel: +256-752647404
Email: Nansanamc@gmail.com /Website:www.nansana.go.ug



REF: CRM 222/1 19th October, 2018

The In charge,
Nakkule Health Centre II

RE: LETTER OF INTRODUCTION – ALBERT COLLINS KYEYUNE

This is to introduce to you the bearer of this letter a student at Uganda Management Institute (UMI), pursuing a Masters Degree in Public Administration, undertaking an academic research on the topic; **"Citizen Participation and Performance of Health Centres in Wakiso District, Uganda: A case of selected Health Centres in Nansana Municipality"**

Please accord him the necessary assistance required.

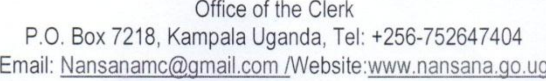
Thanks

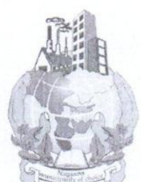
MUNICIPAL TOWN CLERK
19 OCT 2018
NANSANA MUNICIPAL COUNCIL
P.O. BOX 7218, KAMPALA

Daniel Christopher Kawesi
Town Clerk

Copy to;
Her Worship the Mayor – Nansana Municipal Council
Municipal Health Officer – Nansana Municipal Council

NANSANA MUNICIPAL COUNCIL





REF: CRM 222/1

19th October, 2018

The In charge,
Nassolo Health Centre

RE: LETTER OF INTRODUCTION – ALBERT COLLINS KYEYUNE

This is to introduce to you the bearer of this letter a student at Uganda Management Institute (UMI), pursuing a Masters Degree in Public Administration, undertaking an academic research on the topic; **"Citizen Participation and Performance of Health Centres in Wakiso District, Uganda: A case of selected Health Centres in Nansana Municipality"**

Please accord him the necessary assistance required.

Thanks

MUNICIPAL TOWN CLERK
19 OCT 2018
NANSANA MUNICIPAL COUNCIL
P.O. BOX 7218, KAMPALA

Daniel Christopher Kawesi
Town Clerk

Copy to;
Her Worship the Mayor – Nansana Municipal Council
Municipal Health Officer – Nansana Municipal Council