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CITIZEN PARTICIPATION AND HEALTH SERVICE DELIVERY: THE CASE OF ITOJO HOSPITAL NTUNGAMO DISTRICT LOCAL GOVERNMENT, UGANDA

MINI THESIS: SUBMITTED TO THE FACULTY OF ECONOMIC MANAGEMENT SCIENCES, SCHOOL OF GOVERNMENT UNIVERSITY OF THE WESTERN CAPE

In Partial Fulfilment of the Requirements for the Degree of Master's in Public Administration

BY

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DATE: NOVEMBER 2013

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

DECLARATION

I declare that

CITIZEN PARTICIPATION AND HEALTH SERVICE DELIVERY: THE CASE OF ITOJO HOSPITAL NTUNGAMO DISTRICT LOCAL GOVERNMENT, UGANDA

represents my own independent research and, that it has never been submitted anywhere else in University, College or Institution. All sources I have used or quoted from, has been indicated and properly referenced.

……. ……..

Mukiga Alex Kihehere (Student) Prof John J Williams (Supervisor)

Date…… Date……..

DEDICATION

I dedicate this work to my dad Mzee Lauben Kihehere who with lots of love supported my studies under challenging situations, as well as in memory of Oliver Kwitegyese my Mother a dignified Woman raised us against all odds. I also dedicate this study to the Kihehere family, and all my loved ones.

ACKNOWLEDGEMENTS

I want to give thanks and praise to the Almighty God for His blessings, wisdom, good health, energy and keeping His promise of provision and protection. To you God be the Glory.

I owe immense heartfelt gratitude to my supervisor Professor John J Williams to whom I am deeply indebted for his selfless, invaluable, rigorous and critical guidance, patience and encouragement without which this work would have never come to fruition. Special thanks go to my beloved father Lauben Kihehere who supported me financially from nursery school up to tertiary level, thank you dad for everything, may God give you many more years.

Many thanks to the School of Government Administration Staff especially to Ms Lynette, and Bridget Mart, thank you so much for your support and advice. Exceptional thanks are owed to, Ms Elaine Sinden, Sherran Clarence UWC, Mathew Sibanda, Pastors of Eternal Joy Church Bellville and Eternal Joy Church members. I am also grateful to my friends in Uganda especially Dr Tayebwa Edson staff Itojo Hospital for the support during my field work study God bless you, Ms Taremwa Beth God bless you, Taremwa Evans thank you, Bukenya Benard thank you for everything, Ms Diner Nabasa Councillor Kibatsi Subcounty, Atukunda Frank, Ninsima Edina, Tumukunde Moses, Mukasa Richard, the Kateshumbwa family Mwesigye Edgar and Ampaire Edmund who assisted me through my studies. And finally to everyone who took part in this study. Without their sincerity and selfless support, it would not have been possible for me to complete this study. I am also grateful to all my colleagues at UWC for their encouragement and assistance during my study.

KEY WORDS

Citizen Participation

Citizen

Representation

Local government

Itojo Hospital

District

Service delivery

Sustainability

Health

Perception

LIST OF ABBREVIATIONS

DDHS: District Director of Health Services

DDPS: District Development Planning System

DHMC: District Hospital Management Committee

DLC: District local council

DPP: Democratic Participation Process

GOU: Government of Uganda

HSDs: Health Sub-Districts

HSSP: Health Sector Strategic Plan

IFPRI: International Food Policy Research Institute

IRIS: Institutional Reform and the Informal Sector

LC: Local Council

NGOs: Non-Governmental Organisations

NHP: National Health Policy

NRM: National Resistance Movement

MDG: Millennium Development Goal

MP'S: Members of Parliament

MOH: Ministry of Health

OECD: Organisation for Economic Co-operation and Development

PHC: Primary Health Care

PHF: Public Health Facilities

UBOS: Uganda Bureau of Statistics

UDHS: Uganda Demographic Health Survey

ULGA: Uganda Local Government Association

UNDESA: United Nations Department of Economic and Social Affairs

UNDP: United Nations Development Plan

UMHCP: Uganda Minimum Health Care Package

WHO: World Health Organisation

ABSTRACT

As amended in 1997, the constitution of Uganda local government act devolved power to lower units of government to enhance citizen participation and service delivery. Citizen participation was viewed in this act as an instrument through which service delivery and health promotion can be realized. This is done by involving local people in community development programmes such as health that participate on mutual and equal understanding. Citizen participation has proved to work well in some sub units of national governments with key stakeholders at the lower units of government. All this has been aimed at improving standards of living and promoting more participation in decision making for better service delivery.

As highlighted above, this research explores the understanding of citizen participation on health service delivery of Ntungamo district local government. The local government act gives powers to districts to execute planning and administration of district hospitals with the aim of improving service delivery in the districts. The Local Government Act of 1997 spells out that people must holistically participate in the decision making processes of the hospital.

This research report analyzes citizen participation in the provision of service delivery in Itojo hospital Ntungamo district, Uganda. The report is based on data collected from 66 participants via electronic, telephonic interviews and field study done by the researcher with help of one research assistant, and use of district score cards. The study employs qualitative research approach, within which a case study design is used. The study used primary and secondary data based on interviews and open-ended questions. The provisional findings reveal that citizen participation does not necessarily improve service delivery.

CHAPTER 1

INTRODUCTION AND BACKGROUND

This chapter introduces health care service delivery in public health facilities in the context of the study. The chapter outlines the research problem under investigation, research questions, objectives and assumptions, case study area, limitations of the study. A justification for the study is provided and lastly, the organisation of this study is given.

The right to participate in health service delivery programmes was revived in Uganda since 1986 when the National Resistance Movement (NRM) overthrew the General Tito Okello's government (Kamp, 2010, Mwesigye, 2013). From 1986, the Government of Uganda (GOU) started reviving participation frameworks through rapid decentralisation and taking power back to the people. Various districts were created to enhance effectiveness and to improve service delivery in rural communities. Despite all the initiatives, health services are still in a poor condition and some of the unprivileged groups still die of preventable diseases. The poor still struggle to acquire services like education, water, sanitation and health to mention a few. Health, a core focus of this study is viewed as a fundamental human right. In other words, every human being is entitled to it.

The Local Government Act of 1997 decentralized the delivery of health services in order to bring decision making power closer to local citizens. The notion of taking power back to the people over administering, and redistribution of programs has recently become widespread in the developing economies. The move has transferred responsibility of procurement, identification of beneficiaries, and selection of local choices from central ministries to local

governments or community representatives (Headey, 2011). In the 1980s, several countries like Armenia, Bosnia-Herzegovina, Brazil, China, Elsalvador, Georgia, India, Mexico, South Africa, Uganda and Uzbekistan adopted policies on the decentralisation of service delivery (Conning and Kevane, 1999; Bardhan, P. and Mookherjee, 2005, Bashaasha, B. et al 2011). The idea behind this is that decentralizing service delivery to local governments is subjected to electoral pressures. People at the local level keep check of service delivery than a distant central authority. Health organisations have also stressed the importance of citizen participation in health delivery (see WHO 2006 and Alma-Ata, USSR, 6-12, September 1978).

The 1978 world health conference held in Kazakhstan (former Kazakh Soviet Socialist Republic) and the constitution of the World Health Organisation (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006:p.1)[1]. The WHO constitution points out the importance of involving communities in tackling real problems affecting their lives. This is seen as the best measure in making rational decisions pertaining to primary health care and also acts as a link between the local as well as national health systems. The importance of community participation in the mobilisation for better health and disease free society is stressed. Such an arrangement helps create a democratic accountability approach for the management and health workers to the communities (beneficiaries).

The main aim of involving communities in health management is to make sure that the voices of the poor are heard. The focus on involving communities in health planning stems from the

[1] WHO: Definition of health from WHO Constitution. The same is reaffirmed by the Alma Ata Declaration World Health Organization; 2006.

fact that better health is a fundamental human right to every citizen. Health is also seen as a pre-requisite to economic development and poverty reduction. Scholars like Ruiters and Niekerk (2012) also stress that "the right to a healthy life and healthy environment are entitlements of citizenships". It is from this view that the WHO deemed it important to urge both developed and developing countries to put more emphasis on the issue of health in their national and international policy agendas. Therefore, this study's focus on community participation in health at a public health facility is based on the fact that health is a basic human right, and the right to participation should be allowed to local people in determining their destiny (Alma-Ata declaration, 1978 and UNDP, 2000).

1.1. Problematizing health service delivery

In an effort to enhance citizen participation, Uganda has decentralised its health care service delivery (Ugandan Local Government Act, 1997). Although this initiative sounds good, it has not served the intended goal. The local people who are the beneficiaries in this case still struggle to get their health care entitlements and their voices are still not heard. Health services are still in a poor condition and some of the unprivileged groups (poor people) still die of preventable diseases like malaria, meningitis, polio and tuberculosis (UBOS, 2012). The MDG[2] report 2012 '*We can end poverty 2015'* indicates that there are still severe inequalities existing amongst population in both the rural and urban areas. Though its 5 years towards the end of millennium development goal deadline, the report shows that;

- One billion of the world's population will still survive on $1.25 per day,
- Mothers will continue to die during child birth and

[2] MDGs (Millennium development Goals) are eight international development goals that were officially established during the Millennium Summit in 2000 by 189 nations. The aim was to free people from extreme poverty and multiple deprivations by the year 2015.

- Children will continue to die of uncontrolled diseases and this has been attributed to a huge gap of inequalities that exist amongst people.[3]

These inequalities have left the health conditions of the poor in an alarming state with less voice in health participation programmes in Sub Saharan Africa in general and Uganda in particular. Ruiters and Niekerk (2012) observes that in Southern Africa, inequalities cuts across 'racial groups, socioeconomic status, gender, age and geographic location', what they called 'urban versus rural. 'The existence of these inequalities have blocked the local poor people from benefiting in formal democratic spaces.

Decentralised services agitated for by the MDG appear problematic as the many citizens still do not seem to have access to professional medical attention. As a result, the underprivileged still live below the poverty line and are thus unable to acquire health care, water and sanitation services. This still occurs despite the fact that Uganda's health legislative and policy documents include the notion of democratic participation which is pursued as a tool for poverty reduction, community empowerment and promotion of sustainable projects.

Angeyo et al. (2008) assert that since the end of the liberation struggle in 1986, the NRM government tried hard to bring services closer to the people and to improve the well-being of every Ugandan through constitutional reforms. The government took a democratic participation approach to address the health care service delivery challenges by undertaking an extensive decentralization of the public sector and adopting a new national health policy.

[3] http://www.hst.org.za/sites/default/files/MDG%20Report%202012.pdf

Research conducted by IRIS Centre of the University of Maryland shows that at the district level, the government facilitated citizen participation through a decentralization process based on the principle of "The better the matching, the more responsive can and will the government be" (Widlund, 2007: 4 and Azfar, 2007: 96). This principle questions whether government officials at the local level are more informed about the preferences of the local people than the officials at the top. It should be assumed at this point that, the relationship between the service providers and the beneficiaries contributes much in determining the final service. Thus, this research poses the following questions:

1.2. Research questions

1. What are the present policies that ensure and promote citizen participation?

2. What framework exists that emphasises citizen participation?

3. How do the service providers and the citizens relate?

5. What are the perceptions of citizens about citizen participation in a public hospital?

6. What role beneficiaries can play in the course of participating in the management of public hospitals?

7. What are the benefits of citizen participation to the local people in terms of sustainable development?

1.2. Research Objectives

The aim of the study is to examine the effectiveness of citizen participation in enhancing sustainable development to local communities. The specific objectives of this research are:

- To analyse how citizens perceive their participation in hospital services.
- To find out whether or not there are potential service delivery needs and challenges faced in Itojo hospital.
- To establish whether or not citizens perceive an improvement in health services as consequence of their participation.

1.4. Significance of the study and expected outcome

Despite the government's rapid decentralisation programme to enhance local people's participation and improve service delivery, there is less evidence to show the outcome of this initiative and its impact on local people's ability to hold their leaders accountable for poor health services through participatory processes. Yet one of the basic values that form ethical foundation calls for "participation by and accountability of individuals, groups and communities and of institutions, organisations and sectors in health development" (Council of Europe 2000:46). Onzima (2013) argues that there is less evidence of accountability and the inadequate powers to local governments. The previous studies did not consider democratic processes and the functionality of hospital management committees in relation to service delivery. However, this is an explorative study and the findings are not definitive. This research therefore seeks to contribute to the existing evidence.

The research also attempts to find out whether local people fully participate in public health facilities. This is because the participation framework emphasises inclusion of local people in the planning processes. It also sheds light on why citizens still struggle to receive health services. It strives to inform the government; especially the local government to devise some measures to address this challenge and other related issues. Lastly, the research would

contribute to the existing literature to be used by students for academic purposes and by policy makers to enhance efficient service delivery to local people.

1.5. Research assumption (Hypotheses)

The research focuses on the following hypothesis.

The study assumes that *if communities are not involved in the decision making processes at local levels, then the delivery of services would remain top-down and there will be poor services at the local levels*. In this regard, the study assumes that citizen participation processes in the health programmes at the grass root level would improve service delivery and enable sustainability.

The Ugandan Constitution (1995) and the Local Government Act (1997) posit that a citizen participation framework is a prerequisite to successful health planning that can allow citizens to engage in decision making processes in their respective local communities. This has been engineered on many platforms by politicians, academics, public forums, and non-governmental organisations that local people should be in the fore front of any development programmes (NRM Constitution, 2003; ULGA, 2011).

1.6. The case study area

The research case study area is Itojo hospital located in rural areas of Ruhama County in Ntungamo district local government. The researcher was born and bred in this area under study, and he has also been involved in welfare campaigns through youth forum in the years of 2006 to 2009. The population around Itojo hospital speaks one language (Runyankole) and

it is the same language that the hospital employees use to communicate with the local people. The hospital serves the entire Ntungamo district local government and the neighbouring areas. It is the only hospital in the district and one of the 36 health facilities that serve the district. The hospital has lately been in the face of both the media and legislators for poor service delivery[4] and corruption scandals that led to the arrest of the hospital medical supretendant over the embezzlement charges[5].

Itojo Hospital has three Health Sub-Districts (HSDs) which include Rwashamaire, Kitwe and Rubaare with one dispensary and 17 sub-dispensaries. Other health units are available in 26 out of the 88 parishes which are equivalent to 29.5% coverage (District report study 2003). Some patients who cannot be treated at the Itojo hospital are referred to the regional referral hospital in Mbarara district.

1.7. Limitations of the study

The translation of the questionnaire was drawn up in a local language and this makes the English language on the questionnaires broken up. The second limitation was that the time frame of the study was short and therefore did not allow the researcher ample time in the investigation. Lastly, due to the fact that this research was privately funded, the researcher was limited by the funds to carry out a full study.

[4] http://www.monitor.co.ug/News/National/Itojo-Hospital--where-services-are-perpetually-hard-to-get/-/688334/1708302/-/33d4ryz/-/index.html
[5] http://ugandaradionetwork.com/a/story.php?s=40100

1.8. Ethical statement

The researcher sought consent from the University of the Western Cape Higher degrees committee to conduct research in Itojo Hospital Ntungamo district Uganda. The researcher also obtained written consent from the participants to confirm their participation in the study.

1.9. Organisation of the Study

Chapter one: Introduces the topic by providing the problem under investigation.

Chapter Two: Presents the method used to investigate the problem. In addition, it gives explorative background and context in relation to the topic under investigation.

Chapter Three: Presents related literature on the topic. This chapter also provides the study with a firm foundation and theoretical frame work by critically analysing both empowerment and principal agent theory. It further provides related concepts in sustainable development practice.

Chapter Four: Data collected from the different sources is analysed and discussed.

Chapter Five: Gives a summary of the findings. It also provides conclusions and outlines recommendations while noting some areas for improvement.

CHAPTER 2

CITIZEN PARTICIPATION AND HEALTH SERVICE DELIVERY: TOWARDS A RESEARCH METHODOLOGY & THE CASE STUDY AREA

2.1. Research design and Methodology

This chapter is divided into two sections. The first section discusses the methodology used in the study and the second section presents the exploratory background of the study. The research was conducted carefully to answer several research questions that are put forward in the study.

2.1.1. Case study

In this specific study, the case study approach is deemed important by the researcher. The case study approach gives the research a detailed and large sense of the case under investigation. The researcher gets a chance to examine and demonstrate a certain event or incident in a broad context as a whole over a certain period of time (Patton, 1990; Wiersma, 2000; Neuman 2003). Bromely (1986; cited in Cohen etal, 2000), argues that a case study gives the researcher a chance to relate closely the area of interest because of 'direct observation' in a normal setting. For instance, the researcher is able to get near to subjective factor like participants emotions.

Meriam (2002) stress that "the single most defining characteristic of a case study research lies in delimiting the object of the study, the case". Merriam presents the case as a thing, single entity or as a set which is covered by a boundary. The case can be viewed in terms of a single person, a clan, a group of individuals like students, community, teachers or specific government/private policy. A grouped system that adds up a case always possess certain

things in common for instance learners, teachers, taxi drivers, nurses, community or a development programme (Adelman, Jenkins and Kemmis, 1983:3 in Cohen e tal 2000). A grouped system in this study is the citizens of a local government (district) who gets services at a district hospital.

This method helps the researcher to know people better in order of their definition (Mouton 2008). The researcher is able to identify and know people in a better way and also defines them from the observer point of view (Mouton 2008). Hitchcock and Hughes (1995:332) points out that the researcher have limited control over the events within the study even though they form part of the study. Therefore this means that the researcher cannot influence the results. The nature of case studies invites participants to take part in the process and their ideas may be carefully studied and interpreted which also may be used to improve their wellbeing. Nisbet and Watt (1984 cited in Cohen et al, 2000) notes that the generalisation of results is not easy, which makes this as one of the limitation of case studies. This is due to the fact that it depends on the other researchers to view its application in the study and also the observers view. Hitchcock and Hughes (1995:332) points out the possible strengths of the case study as the limited control of events by researchers therefore not influencing the results. The reality of case studies propels the participants to take part in the process and their ideas may be interpreted and used that helps in shaping their own development.

According to Nisbet and Watt (1984 in Cohen etal, 2000), case studies have limitations of generalising results since it depends on other readers understanding of its application. Case studies are not easily open to cross checking, thus this may make them selective, biased, personal and subjective. They may as well suffer bias from observer however much it may try

to address reflexivity. The product may be very long, with lots of information and events that becomes a bulk for busy policy makers and educators to read and use. The research employed qualitative methods of investigation. Lambert and McKevitt (2002) asserts that "qualitative methods are now common in research into the social and cultural dimensions of ill health and health care". The qualitative method in this study is thus employed to analyse primary and secondary information.

2.1.2. Qualitative research

This research approach helped the researcher to get an understanding of the topic under investigation by involving different sources from different respondents. Casley and Kumar (1988: 5) stress that the qualitative method encourages discussion and involvement of respondents who may be individuals, focus groups or village committees. Iphofen (2005) reckons that the method makes the participant more in charge and gains control of what to say as well as determining the flow of their ideas. The study also made use of semi-structured interviews, individual interviews and purposive sampling. This helped the researcher to get more ideas and views from different respondents.

2.2. Sampling Procedures

Purposive sampling technique was used in the study. This sampling technique is a convenient and affordable method of research. Purposive sampling enables the researcher to replace another potential respondent who meets the same credentials in case the person to be interviewed refuse or withdraw from participating (Abrahamson, M. 1983, Gilbert, N. 2001, Moser, C. A. and Kalton, G. 1971). Given the different numbers of communities that get services from Itojo hospital, purposive sampling was found helpful and convenient. The number of respondents comprised of 66 respondents who included, beneficiary (patients), and

the officials (district councilors and hospital workers). This number was chosen based on the compromise between the constraints of time, cost and also the need for being precise.

2.3. Research methods/ instruments

In an attempt to reach this depth of investigation, a number of research tools were used in obtaining and analysing the outcomes in relation to the problem under investigation. This included semi-structured and structured interviews, individual interviews, and purposive sampling. In addition, the use of publications, government score cards, policy documents were also considered in gathering information for investigation.

2.4.1. Pilot survey

The research used sample piloting survey to confirm whether the designed questionnaire suits the targeted groups. This was due to the fact that most people speak their mother tongue but understand simple English. Mouton (2008) observes that 'pre-testing the questionnaire' is very important in a way that it saves the researcher from setting 'ambiguous' questions that cannot be answered by people or violates the rules.

2.4.2. Semi-structured interviews

In this method, open-ended questions are used in the process of interview guide. (Flick, 1998), Semi-structure interviews are used to cut across all the local communities using sampling techniques in order to get in depth information across all races. Therefore, open-ended questionnaires helped the researcher to extract data from various officials and beneficiaries.

2.4.3. Structured interviews

A structured questionnaire was designed to gather data related to citizen participation from both the citizens of the area under investigation and the officials. Interviews for both councillors and hospitals were conducted at their work place. The interviews with the beneficiaries were conducted at the hospital facility. The researcher conducted the interview together with the help of one research assistant.

2.4.4. Individual In-depth Interview

According to DiCicco-Bloom and Crabtree (2006:316) individual in-depth interviews are normally used by researchers in health care to 'co-create meaning with interviewees by reconstructing perceptions of events and experiences' in relation to the delivery of health care. Mouton (2008) stresses the importance of this method in understanding why a respondent is expressing a certain view. This interview approach answers many research questions giving the interviewer an opportunity to clarify some points. This research instrument enabled the researcher to get more detailed information from both the officials and the beneficiaries.

2.4.5. Questionnaires

A questionnaire is a formalized set of questions that help to obtain information from respondents. The main aim is to translate the researcher's information needs into a set of specific questions that respondents are willing and able to answer (Malhotra, 2004). Furthermore, questionnaires give a chance to respondent who cannot take part in the discussions. As Jackson-Plaatjies puts it: "We have found that the meeting times (duration) do not allow adequate time for input from the majority of attendees at these meetings…The main aim of the questionnaire is to give those participants who did not get a chance to speak [the

opportunity] to put across their views and (mainly) their needs". Both closed and open-ended questionnaires were used to obtain qualitative information concerning citizen participation process and its related theories. The questionnaires contained two respondents; the beneficiaries (especially the patients) and the officials of both Itojo hospital and Ntungamo district.

2.5. Data analysis and presentation

The data collected was analysed using thematic analysis to categorise the data collected in different emerging themes. It was viewed well in order to get the consistent flow of interview methods, and was also analysed against the secondary data. Data was also analysed and presented in charts and bars using statistical tool called Statistical Package for the Social Sciences (SPSS).

2.6. Citizen participation and health service delivery in Uganda: Explorative case Study.

The main aim of this section is to explore the background of the case study area. Thus the researcher gives a brief history of citizen participation in Uganda and the legislative framework underpinning the study.

2.6.1. Brief overview of citizen participation process in Uganda

In the new political dispensation, Uganda now marks almost eight years since the revival of multiparty democracy in the year 2005 through a referendum. During this year, the referendum was held to decide on the political system the country would embrace. This culminated into the first multiparty general elections which took place in the year 2006.

Kiranda and Kamp (2010) described this as a milestone for democratic consolidation, nation building and establishing political pluralism.

On the other hand, African historians argue that Uganda's current shape developed as a result of colonisation in the 19th and 20th century (Angeyo et al. 2008). Participation in the struggle for freedom during the 1950's made the country gain her independence in 1962. Before this historical land mark, the country was composed of kingdoms, chiefdoms, and tribes, clans or family set ups. Moreover, there was a minimal form of direct democracy which was practised in few chiefdoms and tribal groups whereas kingdoms under kings exercised authoritarian governance through the royal decree. There is no doubt therefore that the pre-colonial story contributed to a fertile base in finding the origin of democratisation in Uganda (Beramendi, 2009).

Beramendi (2009) further asserts that the country has made a significant improvement with regard to basic democratic platform and multiparty competition has entered Ugandan political space. However, democratic platforms seem to be a hearsay since the state has not created democratic spaces that allow citizens to fully influence the delivery of services they want. Goloba (2005) asserts that ten years down the road, there is no noticeable change in the delivery of health services in decentralised units of government. There is still dilemma of participation, governance, and dictatorship in the implementation of health programmes. Kiranda and Kamp (2010) observe this dilemma as competition between unlevelled grounds merely because it is surrounded by a lot of imbalances. This limits participatory engagements of all parties in development programmes and strengthening institutions for efficient delivery of services. As stipulated in the 1997 Constitution, people's participation should be encouraged at all levels of local government regardless of political affiliation.

2.6.2. Citizen participation in Ntungamo District Local Government

Over the years, there has been a sharp rise of local participation in government decision making processes (Olken, 2010). This has been attributed to decentralised system of governance, where administrative activities are carried out at districts. According to Somanje (2012:49), a district is defined as "a clearly defined administrative area covering a population at which some form of local government or administration takes over many responsibilities from central government departments".[6] It represents all the visions, policies, strategies and road maps to be acted upon at the district level and creates an equal accountability partnership between citizens and government.

According to the 1997 Local Government Act, a district health unit carries out the responsibilities of the central ministry of health. Its size is enough to validate the investment and manage costs as well as being conversant with the relevant demographic and socioeconomic reasons. It is usually equivalent to the administrative district and serves roughly a total of 50 000 to 300 000 people[7], and can be divided when the central government feels that the area is too large to be covered or served by the current local government.

[6] Gorgen Helmit et al. Where districts have many more inhabitants, they should be divided. In: The District Health Systems – Experiences and Prospects in Africa, Manual for Public Health Practitioners, Deutsche Gesellschaft für, Postfach 5180.65726 Eschborn, Germany, 2004, page 32.

[7] WHO. Operational support for Primary Health Care: the role of the district level in accelerating health for all 2000 for all Africans, Brazzaville, World Health Organization, Regional Office for Africa, 1987, (AFR/RC37/TD/1, AFR/HFA/2).

Figure 1: Map of Ntungamo showing population density by sub-county (persons/km2)/ beneficiaries of the study area.

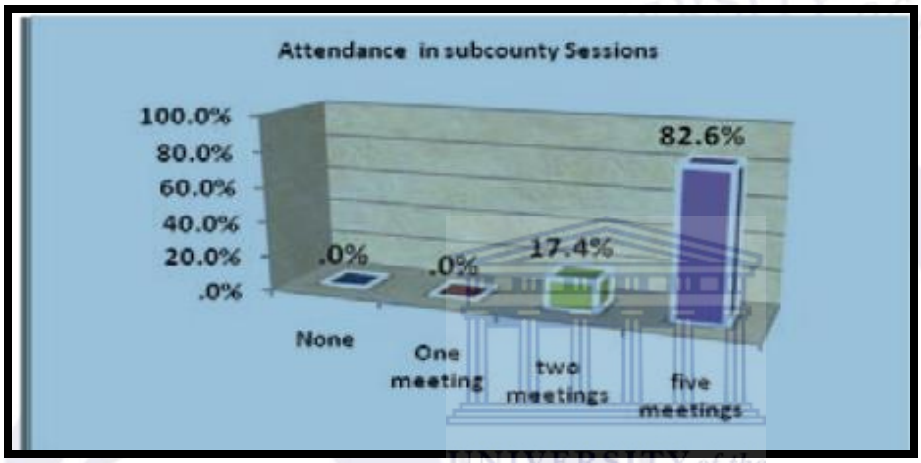
Source: Uganda Directorate of Water Development, Ministry of Water & Environment, 2010.Pg. 3.

The Ugandan constitution as amended in 1997 devolved power to lower units of government e.g. Districts LC IV, Counties LC IV, Sub counties LC III, parishes LC II and LCI Councils. Each district must have a district Hospital headed by the management committee appointed through the district council. The council as appointing authority of the hospital management committee signifies the devolution of power from the central government to the lower units of the district. This is for the purpose of efficient and effective management as well as enabling local people to make their preferred choices. Several scholars have pointed out the significance of involving beneficiaries in the development initiatives to attain long term sustainability (Bentley et al., 2004; Hicks, 2005; Tapscott, 2007; Williams, 2006).

According to the 2009/2010 district council score card, participation in the Ntungamo district is demonstrated by councillors with excellent performance, especially during their sub-county council meetings. The report indicates that the majority of councillors (82.6%) supported their

attendance in the sub-county meetings as shown in the Figure 3 below. There was an exception of a minimal number of councillors (17.4%) who provided attendance evidence of two meetings during that financial year. Poor attendance was blamed on the sub-county leadership, claiming that invitations were always received late and also the collision of sub-county meetings with the district council meetings.[8]

Figure 2: Attendance in sub county sessions



Source: Ntungamo district score card 2009/2010, pg. 14[9].

2.7. Legislative and Policy framework in Uganda

The policy reform on the decentralisation of services in Uganda was launched in 1992 through a presidential policy statement. This was later followed by the local government statute of 1993. The government established a commission known as the Mamdani commission of 1987. This commission advised on the formation of a central government meanwhile retaining the already existing resistance councils into local councils that were later changed into districts (Manyak, et al. 2010). Ugandans later adopted a constitution in 1995

[8] Local government councils performance and the quality of service delivery in uganda.Ntungamo District council score-card 2008/2009. ACODE policy research paper series no. 39, 2010

[9] Also available online at: http://www.acode-u.org/documents/PRS_39.pdf

and the local government act enacted in 1997. The act gave full provisions on consolidating and streamlining the law on local government. The constitution further effects decentralisation, devolution of powers, functions and services. It talks about participation in democracy and provides the political and administrative set ups. This act has so far been amended four times to accommodate all the local councils and units recently created. All this is in an attempt to smoothen the implementation of decentralisation policy that enhances citizen's participation.

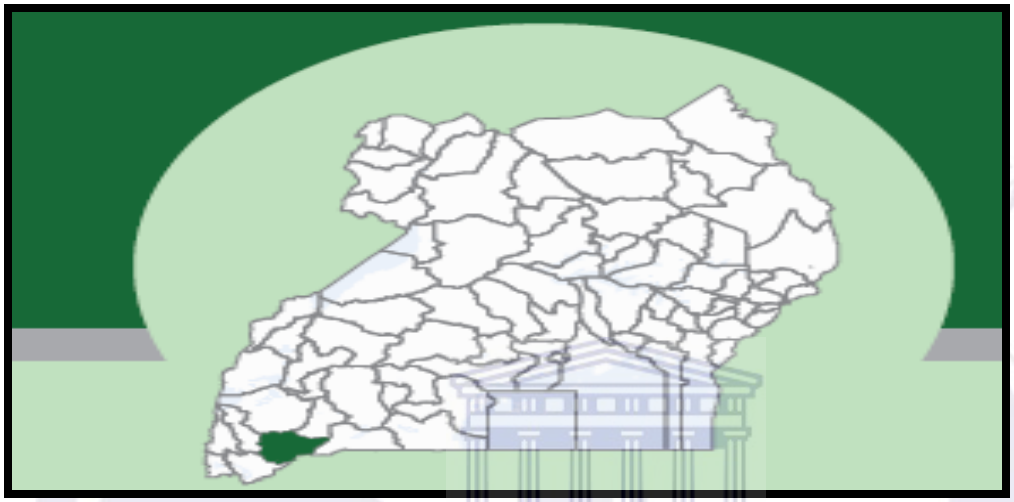
Article 179(40) of the Ugandan constitution provides for the creation of lower units of administration depending on the stakeholders necessities. All these are intended to holistically bring stakeholders on board and draw services closer to local communities. In addition, control for other things like communication, organized settlements, physical planning, geographical and coverage of the available population in a given area are considered.

Policy reforms since the 1990s have also been undertaken towards reduction of both 'morbidity and mortality' from major causes of illness. This was particularly detailed in the health care strategic plan (HSSP) of 2000/1-2004/05 that aims at securing Uganda's minimum health care package (UMHCP) to every household. Basically, it attempts to target all the common diseases faced by local people. The health annual expenditure is normally shifted to areas of greater effectiveness for example, primary health care (PHC), abolition of user fees in public hospitals, expansion of rural lower health facilities, provision of subsidies to private and non-profit making bodies (sub sector), introducing health sub-district structure, increasing the volume of drugs and employing qualified workers. This policy is supported by the

decentralised governance illustrated on the map of Uganda below where the location of Ntungamo district under study is shown.

Map of Uganda showing the location of Ntungamo district

Figure 1: Map of Ntungamo district in the national context



Source: Uganda Directorate of Water Development, Ministry of Water & Environment, (2010). Pg. 365.

As amended, the Constitution of the Republic of Uganda 1995 and the Local Government Act 1997, the public health sector is responsible for the management of decentralised health service delivery system. Their aim is to improve 'health systems capacity to deliver the UNMHCP including health promotion, environmental health, disease prevention, early diagnosis and treatment'. The NHP recognises the population that is in need as the basis of locating 'appropriate' health services. The basic services are therefore informed through the district council who are also represented in the hospital management board/committee.

2.7.1. Hospital Management Board/Committees of public hospitals in Uganda

The Uganda health care systems have hospital management boards for referral hospitals and hospital management committees for district hospitals. Both management committee and boards are headed by nine members who exist on the basis of appointments. They provide governance that links the government and surrounding communities (beneficiaries) in sustainable development. Every district has a district hospital that is headed by a management committee appointed by the district council. In the context of this research, Itojo hospital happens to be among one of the district hospitals in Uganda and is headed by the management committee appointed by the district council (MOH 2003)[10]. These government hospitals are headed by 'medical superintendents who runs the hospital on a day today basis. The medical superintendent is also a member to the referral hospital management board by the virtual of his position together with the hospital administrator as a secretary to the board. According to (MOH 2000) guidelines for the district hospitals, a medical superintendents acts as a secretary to the hospital committee. This organisational structure represents citizens from all the corners of the district.

2.7.2. Organisational Structure of Itojo Hospital Management Committee

The Itojo Hospital management committee follows the guidelines stipulated by the Uganda Ministry of Health (MOH). It is a requirement of any government district hospital to have nine members on its hospital management committee. The Hospital Management Committee is composed of a prominent public figure as the chairman, and the Medical Superintendent as a secretary, all nominated by the district local council (DLC). The committee is also composed of the following as members; the DDHS , the head nursing division, three public

[10]Also available at: http://www.health.go.ug/docs/Guidelines%20on%20Hospital%20management%20boards%20for%20Referral%20hospitals%20%282003%29.pdf

figures appointed by DLC (preferably from different counties of the district, staff representative, Chief Administrative office (preferably chairman of the DHMC, and the Ex-Officio as the hospital administrator (MOH 2000)[11].

The MOH guideline states that 'the committee meetings shall be on the hospital promises' on a quarterly basis. The chairman as the head of the committee decides when to have a meeting in case there is an agent needed or if it is requested in writing by not less than three members of the committee. The function of the committee is to monitor the general administration of the hospital on behalf of the DLC and the MOH. The committee is also expected to foster and improve communication with the public thereby encouraging community participation in health activities within and outside the hospital. It further encourages and facilitates staff development through continuing education and performs any other functions as directed by the appointment authority. However, the participation mechanisms within this committee structure seem to be very weak to allow and foster citizen participation as one of its key duties. The fact that Itojo hospital is the only hospital in the district, it serves three counties and other neighbouring areas. The decision-making power of local people remains a challenge. On the other hand, the councillors in the council are responsible for the proposal, voting and passing of any development planning system to be followed in a given financial year. Therefore, the councillors as well as the hospital committee share the responsibility in the development planning system.

[11] Also available at: http://library.health.go.ug/publications/leadership-and-governance-governance/guidelines/guidelines-hospital-management

2.73. Development planning system in Ntugamo district local government

The district development planning system uses a 'three-year rolling District Development Plan'. All the planning concerning budget and implementation takes the form of an annual basis which encompasses short-term targets planned for each financial year. The district does not have a framework that caters for long term development planning. This makes it clear that their planning system does not favour long term investments. For instance, the council does not have specific targets for the major sectors like health, education, road to mention a few through a number of years. This makes it hard for the council to measure and rate their performance based on the outcome of development and services being delivered.[12]The council is therefore represented in every department of the district. For instance, the council is well represented in hospital management board.

2.8. Background information and Health Service Delivery in Itojo Hospital

This is the only government hospital in the district thus a district hospital. It is located on the Mbarara-Kabale highway, approximately 52 kilometres (32 miles) by road, and lies approximately 22 kilometres (14 miles) northeast of Ntungamo district headquarters. The hospital was built in 1968 by the administration of Prime Minister Milton Obote. Itojo hospital serves the district population of over 380000 and other neighbouring parts of Northern Tanzania and North-eastern Rwanda. It has a bed capacity of 120 which is not enough to accommodate all patients admitted to the hospital. Hence, most of the admitted patients sleep on the floor while others share beds (District report study, 2003).

[12] Local government councils performance and the quality of service delivery in uganda.Ntungamo District council score-card 2008/2009. ACODE policy research paper series no. 39, 2010

The hospital health care is still far from adequate. Services are so minimal due to the poor state of equipment like: Chronic Care Clinic, laboratory, an obstetric theatre, medical waste incineration facility (waste is burnt in open air), lack of requisite radiation protection by X-ray staff, no records of medical waste generation is maintained by the hospital, inadequacy of staff, and staff housing as well as no reliable electricity supply.[13] All these caught the attention of legislators during the 'fact finding mission on how to influence budgeting policy at the lower health units and district hospitals'.[14]

In the past years, the hospital infrastructure changed from bad to worse and this called for the intervention of the area Member of Parliament (the First Lady of Uganda), Janet Museveni in the year 2006. The area Member of Parliament launched a funding campaign from both internal and external sources, to rehabilitate the hospital. In 2007, the Egyptian Government through the Egyptian Fund for Technical Cooperation with Africa gave a donation of US$280,000 to rehabilitate the hospital. This included the construction of three new staff houses. In the following year, Egypt also made further donations of pharmaceuticals, electricity generator and other hospital supplies with a pledge to offer three specialists (a paediatrician, a surgeon and an obstetrician/gynaecologist) to work at the hospital as part of the assistance package.[15] However, the situation has not shown any improvement and patients still struggle to access services at this facility.

[13] Republic of Uganda, Ministry of Health 2010, Environmental and Social Impact Assessment for proposed renovation and equipping of health facilities in Uganda.
[14] Daily Monitor (Tuesday, April 23 2013), MPs traumatised by poor health facilities in Ntungamo

[15]The new vision June, 22, 2011. Egypt supports Itojo Hospital [online] Available at http://www.newvision.co.ug/D/8/13/758290

2.8.1. Health care delivery at Itojo Hospital

The health care at Itojo hospital is still poor compared to the standard of the hospital and the national health policy strategy[16]. Though the hospital is intended to serve the whole district, some patients force their way to other neighbouring districts and private clinics to seek medical attention after a long time of waiting[17]. The hospital has three doctors and one of them functions as an administrator at the hospital. The facility is meant to provide both preventive and curative services that include Immunisation of children, circumcision, HIV/AIDS testing, surgery, and many other consultations. The facility is run by the medical superintendent as the head, doctors and nurses. As mentioned earlier, the facility has a limited number of beds that allow admitted patients to sleep on the floor or share beds with others. There is also no disposal facility at the hospital, thus forcing the hospital workers to burn the disposable stuff/trash behind the hospital building.

The location of the hospital is not in the centre, and this makes it difficult for other citizens to reach the facility for treatment. The hospital has only two ambulances to cover the entire district. More still, the hospital does not cater for fuel to its two ambulances, thus it remains the duty of a patient to buy fuel before making use of the van. As a result of this, patients in critical conditions find it impossible to access medical treatment in time. There is therefore no doubt that, poor families who cannot afford to buy fuel for the hospital ambulances easily lose their loved ones who are in very critical conditions.

[16] The second national health policy: Promoting People's Health to Enhance Socio-economic Development July 2010, page 15.

[17] Daily Monitor (Saturday, March, 2, 2013). Itojo Hospital, where services are perpetually hard to get. [Online] available at: http://www.monitor.co.ug/News/National/Itojo-Hospital--where-services-are-perpetually-hard-to-get.

2.9. Conclusion

This chapter has shown how the government of Uganda ambitiously carried out administrative reforms to promote service delivery at lower units of government. This was carried out through devolution of power from the central government to local government. However, the chapter indicates that local government face challenges with regards to short term planning. The planning system at the local government level is very short thus it does not favour long term investments in health. The government further carried out health reforms for example, with greater emphasis on primary health care, abolition of user fees in public hospitals, expansion of rural lower health facilities, provision of subsidies to private and non-profit sector, introducing sub district structure to mention a few. On other hand, the chapter also indicates that health services in these sub district structures are still poor due to poor state of the hospital facility, congestion of patients in wards, few medical personnel and lack of medicine in the hospital.

CHAPTER 3

EXISTING LITERATURE ON CITIZEN PARTICIPATION AND HEALTH SERVICE DELIVERY: A LITERATURE REVIEW

This chapter discusses the link between citizen participation and service delivery, analysing the relevance of citizen engagement in community development projects. It further discusses the existing literature on citizen participation and community participation. These discussions are grounded on principal agent theory. The chapter assists the researcher to demonstrate the related body of literature with relevant information on the subject matter.

3.1. Citizen participation and service delivery

Citizen participation is the way in which governmental institutions allow communities to take part in the decision making process intended to delineate their operations. It involves a multipartite approach to decision-making in the interest of all (Houston, Mpanyane, and Liebenberg, (1999:78). It is about incorporating the values of democracy in dealing with communities and it emphasizes institutional operations that are responsive to community needs and thereby making sure that service delivery is consistent with community expectations. Thus, citizen participation involves going out to the communities to find out what their needs are. These needs must be aligned with institutional objective conditions in terms of financial and technical capacity.

Participation on its own has become a mile stone of the many development agencies, though its definition is yet not clear. Regardless of its holistic practice in rural development, local people's participation is not limited to stakeholders attending meetings or supporting their work to the implementation of programmes planned by the officials. Citizen participation

means, the active involvement of the people in all development activities (Mwesigye, 2013; Williams, 2007: 106). Once people are fully involved to determine their social affairs, they rally behind every development initiative that helps to fulfil its intended objectives. Therefore, inclusive programmes should be designed in a way that every individual in the community feel as being part of the development.

Verba (1967:53) observes that citizen participation "refers to acts that are intended to influence the behaviour of those empowered to make decisions". In light of this, any community where participation carries more meaning, not being able to participate is a taboo. However, it does not mean that the act would gain automatic success in changing the behaviour of the decision-maker in a way desired by the participant. But constant success can finally show a sign that might be called a "ruling elite" group which can initiate a measure that can finally be enacted by the government.

Several debates conditioned by certain 'theoretical assumptions' seem to present and perceive democracy and participation to have a long and an uneven history. Several scholars have argued that democracy is achieved through participation, yet others are of the opinion that participation only promotes democracy (Dahl, 1956). Robino (2009), points out that, the connection between democracy, participation and more other inclusive models of development is not clear and remains indeterminate. The current patterns of democracy and participation in Uganda are exception in numerous aspects and are also a product of both colonial and post-colonial governments, which are hardly accountable to the citizens and common people with authoritarianism and political uncertainties (Mwesigye, 2013).

According to Cohen and Fung (2004), participatory democracy should engage citizens directly in making choices that concern the public or engage deeply in more practical and political issues that guarantee officials to respond to the concerns being raised. Williams (2007), indicates that local communities can work as tools to influence development strategies through participating in local elections. In this democratic process, rural communities' voices can be heard and their opinions on certain developmental ideas would be considered.

3.2. Community Participation in Health

Community participation in health is a fundamental entity that has been discussed extensively in the literature and even continues to be more helpful to community health workers who implement health programmes (Zakus & Lysack 1998). Thus the confrontation of health service delivery can be successfully done in communities where day to day realities take place. The concept of community participation is sometimes mentioned as citizen or consumer involvement. In health this concept is defined by (Zakus and Lysack 1998) as "a process in which members of the community" collectively with different efforts are able to 'assume great responsibility for identifying their health needs and problems', plan and act to implement their solutions, and also keep in support of their organisations effort, and lastly 'evaluate' the effects then bring about necessary adjustments in the programme as an on-going process. Thus community participation is a mechanism that empowers people to be able to manage and solve their own problems by reflecting on the ongoing situation.

According to Williams (2007: 106), community participation means "involvement in decision-making about the type of healthcare services". Williams (2008) further observes that community participation is 'a key component' to involving local people in the "affairs of

planning, governance and overall development programmes". This has become part and partial of democratic practices. Therefore, the state should legitimately support the poor to access, participate and enjoy their country's human and natural resources. Its economy should pursue developmental programmes that sustain and solve the socio-economic challenges (Williams, 2006). The introduction of new ideas may at times be viewed as the outcome of participation. This is a necessary tool to capacitate and lower the rate of poverty, improve the well-being as well as empower citizens. These further gives a voice to direct or move policies, boast local leadership that will lead to better accountability and institutional engagements (Cornwall and Gaventa, 2001; Cornwall, 2000).

Participation does not only mean people participating in the work done by projects but they must also be involved in the decision making process. Moreover, participation must be democratic in nature i.e. the poorest of the poor has a right to be part of the decision making mechanism affecting their development. The poor must therefore be present when developmental decisions concerning them are being made (Swanepoel and De Beer, 1998: 26). Therefore, effective citizen participation creates ownership and ultimate sustainability of local communities. Richards et al, (2004), observe that evidence from studies in developing countries suggest that 'locally based' and locally owned decisions are more effective in the long term planning. Thus there must be ways/mechanisms that foster citizen participation in local communities.

3.3. Mechanisms of citizen participation

Participation is not a mere meeting with beneficiaries but rather a cycle of engagement ranging from consultation to actual participation processes of governance (Gramberger, M

(2001). Schneider and Zuniga-Hamlin (2005) point out that, this current mechanism has been proven by encouraging citizens and state engagement relationship where citizens are deeply involved in more direct forms of democracy at the grass root level other than being seen as subject to only voting for representation. The current mechanisms highlighted in fostering participation at grass root level mainly encompass different experiences and approaches in different parts of the globe through;

i) 'Raising' civil society's voice,
ii) Reinforcing government responsiveness,
iii) Linking efforts for participatory governance and emphasis on universal health system.

These mechanisms have been approached by different countries in different forms of direct democracy. Direct democracy recognises the fact that the authority of the government and its organs is vested in the people. The people demonstrate their will and consent to who shall govern them and how they shall be governed. This is done through regular free and fair elections of their leaders or by referendums and also recall. There are four forms of direct democracy which are practiced in different governments that allow democratic practice, and these are; *referendums, citizen's initiatives, agenda initiatives, and recall*.

Beramendi e ta l (2009), defines *referendums* as 'procedures which give the electorate a direct vote on a specific political, constitutional or legislative issue'. According to the Constitution of Uganda, Article 69 of the (1995), the people of Uganda shall have a right to choose and adopt a political system of their choice through free and fair elections and referendums. The constitution states that referendums may be called by political authorities or by a certain number of people commonly known as *initiatives* if citizens are able to gather a minimum number of signatures specified by law to bring an issue to a vote. Beramendi defines political

authorities as "executive or legislative institutions of the government". These authorities may be at various levels of government, for example national, regional, provincial or local level. As indicated above, different procedures are also available that allow citizens or a minority in a legislature to demand a referendum if there is an issue. For instance, the Constitution of Uganda under the article 255 states that parliament shall by law make a provision: (a) for the citizen's right to demand the holding by the Electoral Commission of a referendum, whether national or in any particular part of Uganda, on any issue; and (b) for the holding of a referendum by the Electoral Commission if the government refers any contentious matter to a referendum.

Beramendi (2009) also mentions *agenda initiatives* as one of the mechanisms of democratic participation. He defines agenda initiatives as "procedures by which citizens can organize to place a particular issue on the agenda of a parliament or legislative assembly". Rule 105 of the parliament of Uganda accepts private citizens to propose new laws and even change the existing laws by submitting to parliament a private members bill. Several of these laws have been amended following the request from the public. This is done by submitting a minimum number of signatures specified by the Uganda constitution and forwarded to the legislature. This particular mechanism of participation, the channels that are followed for citizens' initiatives, in this case is done differently; no popular vote takes place when an agenda initiative is brought forward.

Lastly, Beramendi (2009) further discusses *recall* as a mechanism for the popular democracy. He stress that recall procedures gives electorate power to decide on whether to terminate the term of office of an elected official if significant number of signatures to support the recall is

reached. However, it is good to note that recall only deals with the removal of a person from the public office and the outcome is always binding. Under article 84 and 185 of (1995) Constitution, the parliamentary and local government act, allows citizens to recall their representatives. However, under the presidential election act the recall of the president is not possible.

The popular mechanisms of democracy discussed above are always initiated by citizens in situations where they feel that service delivery is under threat. Thus citizens should be allowed to voice out and influence their views on how they wish to be served. This is due to the fact that in health, service delivery and sustainability can easily be attained when citizens are involved.

3.4. Health Service Delivery and citizen participation

The WHO report (2008), stresses the need for communities to holistically be included in participation process. This is meant to ensure sustainability and 'people-centred' health services which improve the overall performance of the health facilities. For instance, the effectiveness and management in the service delivery of the decentralised units like districts, relies on the 'competence' of a number of members in the district health management teams within the health facility. Their competence enables excellent 'planning, implementation, monitoring and evaluation' of health service delivery (WHO 2008).[18]

[18] WHO Habib Somanje etal...African Health Monitor issue #15 June 2012.Summary Resume: Health Systems Strengthening: Improving District Health service Delivery and Community Ownership and Participation. World Health Organization, Regional Office for Africa.

The main purpose of health systems is to give people proper care through provision of 'comprehensive, integrated, equitable, quality and responsive' crucial health services (WHO 2008). This enables needy people to access the health services whenever they need them and enables universal coverage. This allows for effective utilisation of health services by the beneficiaries regardless of race, education level, geographical location and economic status. Continuous community action helps to uplift health and disease prevention which is the most effective way of sustainability.[19] According to Menimo et al. (2010:79)[20], 'health and territorial development councils' have worked better in policy making where 'popular participation' through institutionalised units are emphasised. Menino cites one example of Brazil where municipalities and other small units of government are responsible for implementation and management of local units that work within the standards of National Health council.

Kim et al. (2013) also stress that global health framework is a prerequisite for a 'better health for all'. This terminology was over emphasised during the Alma-Ata Declaration in 1978. Kim et al. observe that the focus should shift to delivering value for patients. They define value as "a measure of the aggregate health outcomes achieved per dollar (or pound or rand, etc.) spent" Kim et al (2013:2) On the other hand, most government health facilities continue to struggle to account for the value of health. Kim et al. emphasise that the purpose for "product of a delivery system is health not treatment per se. Quantification of treatments received is a crude mechanism of evaluation relating to the volume model of health care"

[19] WHO. *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium*, Brazzaville, World Health Organization, Regional Office for Africa, 2008

[20] Also available online at: http://www.drc-citizenship.org/system/assets/1052734707/original/1052734707-mohanty_etal.2010-states.pdf

(Kim et al 2013:2).[21] Therefore, patient's value should be fully recognised in delivering health treatment.

Patient's value here is defined from the whole process of care for the patients 'health problems' together with the results or outcomes other than the amount of discretion involved or services. They proposed a global health framework where the value created is understood in four broader levels.

First level: By integrating care for every individual medical condition over the full cycle of care, using the concept of the care delivery value chain.

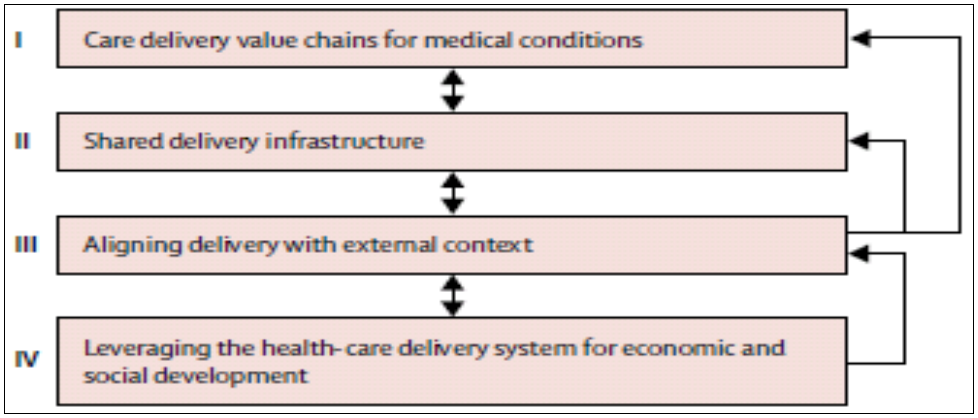
Second level: 'By using shared delivery infrastructure across medical conditions to capture synergies in preventing and treating related and concurrent medical conditions and to a better use of personnel and facilities'.

Third level: 'By incorporating knowledge of local patient and community constraints to delivering value in the design of concept of the care delivery value chain and shared delivery infrastructure'.

Fourth level: 'By designing health delivery systems to maximise their contribution to equitable economic and community development, thereby relaxing underlying constraints to health and to the delivery of high-value care'.

[21] Also available online at: http://press.thelancet.com/healthcaredelivery.pdf

Figure 1: A framework for global health delivery



Source: Kim et al. (2013).[22]

However, this model can suitably work in strong economies where there are no challenges of labour shortage, finances, and good governance. At the same time, this model can still be implemented in decentralising health services. This will help in the planning of decentralised health facilities and also assist local governments in its sustainability.

3.5. Decentralized health planning

Over the years, decentralization has been tipped as a perfect mechanism to improve health services. Lately, it has been viewed as a fundamental means of a wider health reform to attain 'improved equity, efficiency, quality and financial soundness'.[23] Coelho and Nobre (2004) observe that local councils should be responsible for the overseeing and authorizing annual plans from the 'health service managers' at every government level.

> *"Decentralization of health services provision has also resulted in the mandatory establishment of local health councils at state and municipal levels. As well as*

[22] Also available online at: http://press.thelancet.com/healthcaredelivery.pdf
[23] Thomas Bossert, (1998): Decentralization of Health Systems: Decision Space, Innovation and Performance: Harvard School of Public Health 1350 Massachusetts Avenue Holyoke 723 Cambridge MA 02138e-mail: tbossert@hsph.harvard.edu

guaranteeing local access to national funds, these councils have come to play a key role in local politics, becoming important arenas for participation, decision-making and public accountability for the government's actions". Menino et al. (2010:82).

The Constitution of the Republic of Uganda 1997, decentralized health services to local government level. This was done to promote public participation in decision-making on the affairs that affect their lives. However, decision making does not necessarily mean implementation or acting upon such decisions. The nature of decentralization does not fully guarantee action upon decisions being made by the citizens. Decentralized health planning needs the access to resources which are in most cases controlled by the national government. In this regard, the WHO health system framework gives provision for the decentralized health planning. Therefore, health planning needs to recognise the building blocks for health system strengthening.

3.6. The Six Building Blocks of A health system

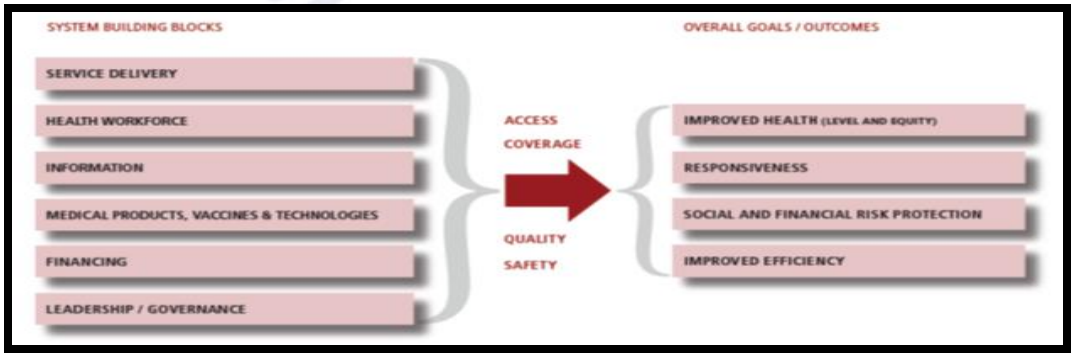
The World Health Organization defines a health system as "all organizations, people and actions whose primary intent is to promote, restore and maintain health".[24] The WHO (2007), identified the six building block models needed by any health system in order to achieve their goals and targets. These are seen as the most important basic functions that all health systems should consider regardless of their better organisation. All health systems are required to ensure that there is provision for the services, development of health workers and other major resources, mobilisation and allocation of finances, and better health system leadership and

[24]See report at: http://www.aho.afro.who.int/sites/default/files/ahm/reports/441/ahm1509.pdf

governance (which also can be seen as stewardship that includes oversight and guiding the whole system). These functions were identified in the WHO report of (2000) and have been broken down into a set of six crucial 'building blocks' that form the WHO's health system framework.

1. Service delivery: 'packages; delivery models; infrastructure; management; safety & quality; demand for care';
2. Health workforce: 'national workforce policies and investment plans; advocacy; norms, standards and data';
3. Information: 'facility and population based information & surveillance systems; global standards, tools';
4. Medical products, vaccines & technologies: 'norms, standards, policies; reliable procurement; equitable access; quality';
5. Financing: 'national health financing policies; tools and data on health expenditures; costing';
6. Leadership and governance: 'health sector policies; harmonization and alignment; oversight and regulation'

Figure 5: The WHO health system framework



Source: (WHO, 2007 p.36).

This means that citizens need to be the main force in determining the type of health to be rendered to them.

3.6. Citizen participation in planning process within the health system framework

For any process to be participatory, the interested and affected parties have to be considered and fully represented in the planning process (Richards et al., 2004). Participation would be weakened if there is misrepresentation of stakeholders. Pain and Francis (2003) cited in Richards, et al. (2004:13), note that some challenges emerge when dealing with 'hard to reach' category of population. Pain and Francis uses examples of 'elderly or young people, non-English speakers, and spatially or socially isolated groups such as homeless'. William (2007) views the idea of "bottom up" as people centred integrated development planning that encourages local citizens to holistically participate in matters of local government. According to Barya (2000) cited in Williams (2007) the rights-based approach to participation in development arises from legal construction. Local communities are part of decentralized units of governance as they have decision making power on behalf of stakeholders at the grassroots level (Bosch 1999).

The central government sometimes intervenes to challenge 'local elites' to respond to the requests of the local people. In this regard, Crook and Sverrison (2001) observe that effective participation by the local people in the community development programs, can counter the elites. Their participation in the local government structures indicates the presence of political space to challenge uneven associations of powers at the grass root and beyond (Kanyinga, 1998). Bossert (2000) argues that the participatory processes seek to create a balanced interest in order to escape from being taken away by special interests (Williams, 2007). He also says that this requires institutions to be flexible and responsive to calls for change. This can be

achieved by putting into consideration the strengthening capacities of interest groups; being aware of health issues; articulating specific interests; engaging in consensus building activities; negotiating and lobbying different decision making arenas, and participating in the implementation and monitoring of health sector reform (Sunstein, 1998). Furthermore, Williams (2007) draws from Bosserts judgment that some interest groups may possibly organize and express their interests more perfectly than others. In view of the above, Bossert argues that once interest groups have their full investment in the specific sector, for instance health, then their stake in the policy process becomes continuous. This proves to be a vital challenge of participatory governance.

3.7. Challenges to Participation

Several scholars believe that there is still a gap between the speeches and reality of participation (Richards, et al. 2004). The main aim is to know the limitations that prevent the theory from being put into practice rather than producing the procedures that look like those which exist. Richards, et al. (2004) discuss six challenges facing participation as;

(a) *Managing expectations*- through open and flexible discussions, expectations and 'wish-lists' are raised by the participants.

(b) *Identifying non-negotiable positions* - Where problems or their consequences are complex, large scale and irreversible, it may not be possible to give free rein to participants to determine environmental decisions.

(c) *Constraints to full 'citizen control'*- The success of participatory approaches sometimes depends on people whose influence may be difficult for the initiator to detect.

(d) *Adequate Resources*- Participatory processes can be time- and resource- hungry. Failures are frequently attributed to a lack of resources being devoted to engaging with stakeholders or implementing outcomes.

(e) *Reaching Consensus*- While there are obvious benefits to reaching a consensus, there are also many risks in making this a specific aim of the process.

(f) *Selecting an Appropriate Scale*- Tensions often exist between bottom-up and top-down approaches to policy making.

However, several scholars indicate that the participatory approaches which are applied are not necessarily intended to give a voice to the citizens and this make it hard to carry the meaningful message to the beneficiaries (Williams 2006, Cook and Kothari 2001). Most of these programs have been either pushed to better a certain interest group or create ceremonial presence of participants in their area of interest. As Cooke and Kothari (2001) cited in Richards C et al (2004:16)[25] explain, "*Despite best intentions, participatory approaches do not always empower but may unwittingly serve to legitimize and support the status quo*".

The nature of community participation and its impacts on different generations depend entirely on how wisely local leaders consider peoples participation as a form of empowerment and ownership (Williams, 2007). Williams advises that citizens should be aware that rights to participation do not merely occur but it's only when citizens demand power to effectively take part in decision making. **"**It is only when people claim or demand power to achieve specific concrete goals (such as implementing a specific plan, project or programme, that presence,

[25] Also available online at: http://www.macaulay.ac.uk/serp/research/SERPpb1.pdf

participation and voice assume experiential significance at local level. This means that participants must be aware of their abilities to make judgments, how to effect meaningful change and how to play political roles as a citizen*"* (Williams, 2006:203). For such changes to happen, citizens must act in a well-defined process (Wondolleck & Manring, 1996). Citizens need to be empowered in order for them to know and understand certain processes. The principal agent theory describes this dilemma as where the principal try to overcoming the information symmetry that the agent has in his control.

3.8. Principal agent theory

Economists developed principal-agent theory to test the choices that are usually made by managers of Private Corporations (Pratt and Zeckhauser, 1991). Several scholars in (Bossert 1998:1516) also assert that it has been used by economists and political scientists to evaluate 'federal intergovernmental transfers to states in the united states' (Frank and Gaynor (1993), Chubb, 1985; Hedge et al., 1991).' Dranove and White (1987) cited in Bossert (2002) observe that sociologists, economists and several scholars have also used agency theory to analyse the coordination between provider and the patient.

The principal-agent theory was originally developed to explain the relationship between private contractual parties such as landlords and tenants or owners and managers[26]. When there is an agreement between one or two parties to work together within a hierarchy or on the lateral basis, the parties are compelled to enter a kind of contractual relationship (Kusnanto, 2002). In this contractual relationship, one party has the objectives which are supposed to be implemented by the contracted party in order for the other party to achieve those objectives.

[26]Available online at: www.hsph.harvard.edu/takemi/files/2012/10/RP198.pdf

The two parties proposed in this theory include a principal (individual or institution) with certain objectives, and agents who are supposed to implement given activities in order to achieve those objectives. These agents may share some objectives with the principal but can as well have (sometimes self-led) interests like boasting their own income. Agents have more specialities in what they are doing than the principal. This puts them in a more advantageous position and gives them the space to pursue their own interests at the expense of the principal. The principal might want to overcome this information asymmetry. However getting the information has major costs effects and might be difficult. This as a result forces the principle to pursue his objectives by shaping incentives that are in line with the agent's own self-interests. The principal can also use selective monitoring and punishments to encourage agents to implement activities to achieve these objectives. In most of the models that use the principal agent approach, it is assumed that the principal receives the benefits of any profit that is produced by the agents. In addition to the information asymmetry, the principal agent theory also focuses on issues of control of information and monitoring (see empirical studies of Chai, 1995 and Hurley et al., 1995).

Applied to decentralized health systems, we might use the principal agent framework to view the department of health at the local government as a principal with the objectives of equity, efficiency, quality and financial soundness (rather than profit as assumed in the economic models). The local health/political elected officials are seen as agents who are given resources to implement general policies to achieve these objectives. This theory encourages us to monitor the relationship/interaction between the principal and the agent in the event of monitoring performance of the agreed contract.

Principal agent theory has been criticized for its prime focus on the vertical relationship between the principal and the agent. This makes it difficult to study multiple principals, especially if they are of different administrative levels. Some analysts have taken this problem as a crucial weakness in the principal agent theory (Hedge et. al., 1991). The participation at the decentralised health systems results to the need of empowering local citizens. This however implies that those who manage the local health system will be accountable to the local population (or local political system) who become additional principals and who may have quite different objectives from those of the principals at the national level.

On the other hand, the principal agent theory can as well accommodate multiple principals. The multiple agent analysis focuses on a vertical chain of principals whereby, the "people" as principal, elects the 'Congress' as agent. This in turn, acts as principal over the government bureaucracy which acts as agent (Moe, 1991). Multiple principals can be competitive (in a manner like- 'Congress vs. the President') and the theory can still inform us on this relationship. 'There is no inherent logic in principal agent theory which prevents this analysis from including multiple principals at either the national or the local level' (Bossert, 2002:7)[27]

Therefore participation in the decentralised health system, local governments are compelled to respond in order to elected officials (Legislators [councillors, MPS], LC Chairpersons, mayors,), who are in turn, agents of the principals in the local political process (electorate and/or multiparty political coalition). The goals and interests of these local principals will shape the response of the municipal health officials to the incentives and rewards of the central government. Thus, an analysis of the recruitments of health professionals at local

[27] Also available online at: http://www.hsph.harvard.edu/ihsg/publications/pdf/No-54.PDF

governments and those who are recruited through the national centralized system will give a clear picture of service delivery challenges encountered when the recruitment is based on the local government's mandate.

In most cases, the staff recruited in the decentralized health systems are the same as the centralised staff of the Ministry. In this case, the staff appointed at the decentralised health system will have less or no chances of being promoted to the higher level as a form of remuneration for work well done. These will demoralise their initiatives to work hard and improve health services. But it's most appropriate in cases where there are de-concentrated forms of decentralisation, and the regional staffs can be simply transferred from the Ministry of health to the local government (districts). This transfer may bring appropriate skills that would be lacking in the health facility, but it also transfers the structure, culture and routines of a highly centralized institution.

3.9. Conclusion

This chapter has indicated different ways in which citizen participation can improve the health service delivery and how best it can be implemented to promote sustainable development. The chapter has stressed the need for local people to take part in decision making processes, and this is also clearly indicated in the health system framework. The health system framework has also indicated how a set of a system 'system building blocks' is fundamental in achieving the overall goals/outcome. Achieving all the objectives has also been seen to be possible if local people are involved the planning processes. However, participatory processes tend to be challenging due to various groups with different interest than others. This makes participation hard due to obstacles in overcoming information symmetry controlled by the interested

parties. Principal agent theory also indicates this dilemma between the principal and the agent. The principal try's to overcome the information symmetry which the agent has control over but it is difficult due to the costs involved.

CHAPTER 4

TOWARDS UNDERSTANDING CITIZEN PATICIPATION AND HEALTH SERVICE DELIVERY, ITOJO HOSPITAL NTUNGAMO DISTRICT UGANDA

This chapter of empirical findings is answered based on the objectives of the study presented in chapter one. The answers to the objectives were obtained using structured and semi-structured interviews with both the officials of Ntungamo district, Itojo hospital and the beneficiaries of the hospital. The researcher also used in-depth individual interviews to gather information from the district and health officials.

4.1. Analysing objective 1: To analyse how citizens perceive their participation in hospital services.

This section of the study analyse the participants perceptions on citizen participation processes. However, part of this objective has already been answered in chapter two and three above.

4.1.1. Participants perceptions on citizen participation

This section explores local people's (beneficiaries) perceptions on citizen participation processes. The participants' perceptions about citizen participation processes were quite different. The study reveals some variations on how they perceive citizen participatory processes. The response from participants further indicates how they perceive their influence in participation. For example about who have influence in making decisions and determining the appropriate delivery of services. Some believe that their participation in voting by the majority, gave them voice to influence those who make decisions. The question posed by the researcher about the recall of a leader in case there is under performance and poor delivery revealed some form of autocracy. Some response indicates that the procedure for recall is too long for communities to cooperate and achieve. Though the constitution have a provision

where local people can recall their representatives from the council or parliament, their responses showed that it is difficult for a recall to happen under the stated procedure. One of the respondents said "it has never happened here, and I don't think it is possible to happen, they need a long process to do it which is hard for common people, but even those who would wish to do it get scared because they don't know whether people will cooperate". They however said that there is an open platform where people can voice their views on how they should be governed. These platforms are for example a radio show, where people call in to express their concerns on service delivery. Despite the participant's different perceptions about citizen participation, the following themes emerged from their responses as forms of citizen participation.

4.1.1.1. Voting for representatives in different positions of power

The participants' perceptions indicated that voting at elections is one form of citizen participation. Most of the respondents perceived this as a sign of power to the people once the majority wins, yet others perceived it as a decision that is made in direct democracy. The respondents' views present a clear picture on how they perceive citizen participation. Some of the respondents explained their perceptions as follows: "I understand this as being involved in political behaviours and making your leaders accountable through voting mechanism", a second respondent said "It refers to who is eligible to vote, what is decided through direct democracy", a third respondent said "Its power in the hands of the majority", a forth respondent understands it as "Power taken basing on the majority", and a fifth respondent said that "People have power to choose what they want". The notion of citizen's power has been supported by scholars like Arnstein (1969). According to Arnstein (1969: 216), citizen participation is power. Some of the respondents stressed that through voting for their

preferred candidates, their voices are heard and they reserve the power to vote them out in case they fail to deliver. Williams (2006) also recognises the need for citizens to fully engage in all forms of participation in order to claim their full rights of participation. He indicates that "It is only when people claim or demand power to achieve specific concrete goals (such as implementing a specific plan, project or programme, that presence, participation and voice assume experiential significance at local level. This means that participants must be aware of their abilities to make judgments, how to effect meaningful change and how to play political roles as a citizen" Williams (2006:203).

In Uganda, voting is conducted under the multiparty system, where citizens choose their preferred leaders within the party. Individuals are also allowed to vote for positions of power as independent candidates. Both the councillors and member of parliaments chosen through this process are responsible for making decisions in planning and making policies on behalf of citizens. Wampler and McNulty (2011)[28] point out that this is the outcome of more than two decades of experimentation which has become evident that there are numerous experiences that fall under the rubric of participatory governance. These scholars draw the example of Uganda's participatory constitution-making process sponsored by the World Bank as one of the clear experimentation of participatory governance. Scholars like Nickson (2011: 12) have stressed the importance of citizen participation in the improvement of service delivery through fostering transparency into resource allocation towards the interest of the population.

[28] Also available at: http://www.wilsoncenter.org/sites/default/files/CUSP_110108_Participatory%20Gov.pdf

4.1.1.2. Consultation of citizens through public gatherings

The response from the participants also indicates that they perceive consultations with the public through annual general meetings and community gatherings as a form of citizen participation where citizens raise concerns that affect their society. A majority of the respondents emphasised that citizens should be consulted before services are delivered to them; "people should be consulted on how to deliver services to them". The interviews with the officials indicated that government programmes that were planned without local people's knowledge became a challenge to be implemented. According to Schwartz and Deruyttere (1996), 'to consult means to inform the other', a community needs to be informed on why, how and where the new programme will be launched. They further stressed that communities better understand the local terrain and can identify the unforeseen challenges. Bjorkman and Svensson (2009) indicate that involving communities in health programs improves the performance of health workers and subsequently the health conditions. From their findings of a random research done in 50 communities, 9 districts showed that there was an improvement of treatment in communities as a result of community involvement.

4.1.1.3. Taking part in health promotions and demanding better healthcare

The participants' response also indicated that several programs in communities are perceived as a form of participation and need individual's willingness to take part in such programs. Many programs are arranged in a non-selective way which means that they holistically invite every individual in the community on board to take part in its running. This is in line with one of the respondent's response about how he perceives citizen participation; "I think this is a process by which services are provided according to the needs of communities or where communities participate in making policies governing them in the process of service

provision". Another respondent said that "It refers to being active member of society and actively help in its restructuring". The participants emphasised that most of these programs call for every community's member's initiative, especially in health department when there is an outbreak of a deadly disease. Their response is in agreement to that of health workers who were satisfied with communities' response to health immunisation programs for diseases like; Diphtheria, polio, tetanus, tuberculosis, measles and whooping cough, Hepatitis B and Hib, pneumonia, cervical cancer, rotavirus infections. Midwives at the hospital, were also satisfied with the responses of men accompanying their wives in the antenatal care clinics; "At least health campaigns have increased numbers of men coming to the clinics accompanying their wives". Her response is in line with what the general practitioner said; "We have been encouraging people to participate in health issues like testing for HIV, Circumcision, men to accompany their wives in antenatal clinics and bring women to the hospital for delivery to avoid delivery death at home people have responded positively" According to WHO (2002) for health promotion to be successful, people must be involved in order to prevent, be part of preparations for and respond to threats that may occur in the community. Community participation is therefore the 'basis of successful health promotion'.

4.1.2. Participants perceptions on mechanisms facilitating citizen participation

The participants were asked using open-ended questionnaires and in-depth individual interviews to elaborate on their perceptions about mechanisms that exist to facilitate citizen participation. From their responses, the following themes emerged as channels that have facilitated citizen participation of local people in hospital programs.

4.1.2.1. Free access to healthcare services

The participants' perception on citizen participation in this study indicates that there is a big improvement in the number of patients who access the facility. The study reveals that this improvement is said be as a result of the government's decision to abolish payment of user fees in public health facilities. Their perceptions further indicate that poor patients are no longer limited by finances to access the facility as it was the case before the government striped off the user fee policy. However, the responses from the participants in this study also demonstrate that the free access to the facility does not guarantee the availability of services at the facility. The response from one of the general practitioners at the facility indicates that services are still far from reality. He was not satisfied with the fact that the user fees of private clinics at the facility were stopped, which according to him helped to support the quality of services offered. "The private clinics at the hospital helped us a lot in facilitating and beefing up the day to day running of the hospital. The budget we get from the central government is not enough and that's why most of our colleagues left". According to him, this was one of the factors that made most of the health officials to leave the facility. His argument was that the user fees from the private clinics within the facility helped in motivating of the hospital staff. Other daily activities of the hospital which cannot be covered by the current budget allocated to hospital by the central government were also covered by these private clinics.

However, from the respondents' point of view, there is still indirect payment of the user fees in public health facilities. The response from an interview with one of the general practitioners indicates that patients still pay money to fuel ambulances and the hospital generator in case there is a need to use one of these facilities. He also stressed that patients at

times after operation find their way to private clinics to buy pain killers after spending two days of waiting for pain killers from hospital nurses.

4.1.2.2. Raising people's voice through Public Hearings

The officials believe that listening to people's views have made a great improvement in the participation in health programs. The officials stressed that there are several channels that are being used to create awareness among communities. These include: community radio presentations, TV shows, community gatherings, church visits and school visits. During these gatherings, the local people raise their concerns to their representatives in the council and parliaments, and also the heads of social welfare committee. They stressed that the collaboration of leadership have improved the performance of health promotion programs. For instance, the reduction of HIV scourge in the district has been due to a strong link between local leaders and health officials which makes implementation easier. The hospital also provides a suggestion box where people express their dissatisfaction in case they are not happy with the services.

However, an interview with one of the hospital administrators indicates that people rarely use the suggestion box because they feel that even if they do, no one will ever open and read it or even if they read it, nothing will change. He pointed out that people believe that government services never changes and it is the same reason why those with better background force their way to private hospitals in search for better services. "Local people who afford private clinics don't even mind, most of them chose to go to private hospitals because they believe that public hospitals services never change". The response from the beneficiaries indicates that people who go to private hospitals go there to get medication. They pointed out that even

though patients are diagnosed in the public hospital, they are referred to private clinics to buy medication.

On the other hand, the interview with one of the district councillor indicates that people have platforms where they can lodge their complaints in contention to service delivery. She said that councillors and social welfare committee of the council are always open to listen to peoples complaints concerning service delivery[29]. There are also public hearings that are once in a while arranged in communities for people to express their views to their representatives in the parliament and the district council. According to Sewell and Coppock (1997:105), hearings can be heard at different strategic areas around the communities concerned. These scholars further stress that the timing, setting and length of these hearings must be in agreement with the community (Sewell and Coppock, 1997:106).

4.1.2.3. Non Selective Health Orientation Programmes

The response from the participants indicates that orientation programs have played a vital role in the improvement of participation amongst families. One of the councillors stresses, "I think the reason for participation is that we have government programs which are non-selective and includes all genders and different groups. Here we don't have groups which are marginalised, so if someone doesn't take part, it means that him or her as an individual is naturally not developmental". Bjorkman and Svensson (2009) point out that involving communities in health programs improves the performance of health workers and subsequently the health conditions. From their findings in a random research done in 50 communities, 9 districts of

[29] Social welfare committee is composed of councillors appointed by the district council and are responsible for all social problems affecting local communities. They are tasked to report to the district council after every quarter (three months).

Uganda showed that community involvement played a vital role in strengthening participation of all parties involved in rendering services. However on gender perspectives, the response from councillors indicates that most of these programs are dominated by only women. The councillor stressed that men do not fully take part in participation. However, she did not give an explanation of their unwillingness to participate. She goes further to say that: "Men lie behind in terms of participation in government programs due to their unwillingness to take part. There is always been a debate in the council on social problems where we have found out that men spend most of their time in bars drinking". According to Thompson (2012), this situation indicates that democratic framework does not fully incorporate local people to willingly participate in formal democratic spaces.

4.2. Analysing objective 2: To find out whether or not there are potential challenges faced to access hospital services.

Using structured and semi-structured interviews, the district officials, beneficiaries and hospital officials were asked about the challenges being faced to enhance service delivery in Itojo hospital. Part of this objective was also discussed in chapter two where challenges in development planning were highlighted as one of the barriers in building a sustainable delivery of health services. This section gives a clear picture of officials' perspective on the state of health service delivery in Ntungamo district.

4.2.1. Perceived health service delivery needs

The response from both Ntungamo district and Itojo hospital officials demonstrates a compelling gesture. The officials were asked about their perception on service delivery needs raised by Ntungamo district residents. The 25 officials (100%) that were interviewed in this survey indicate that their perceptions on the service delivery needs is high and this was also

confirmed in the in-depth individual interviews that were done with both Ntungamo district officials/councillors and Itojo hospital officials. The results of this survey are presented in table 8.

Table 1: Perceived service delivery needs

	Frequency	Percentage (%)
YES	25	100.00

Source: Author's fieldwork 2013

The officials being interviewed indicated that there is a challenge of shortage of medical staff and absenteeism due to lack of management. Among the respondents, one of the medical staff said that, "The expected percentage staffs in the hospital are 39% but most of the staff normally does not report, and even when they report, they come in late and leave early. So you can imagine, some time back, we had only one midwife who would conduct and administers 90 patients, goes to the store to fetch medication and carry out 12 deliveries per day. The management is still a challenge here in this hospital. Our medical superintendent is the district health officer, so he sometimes comes once a week or sometimes doesn't come. Supervision is very poor, everyone does as he pleases". The medical personnel also pointed out that there is "late delivery of drugs from the national medical stores", which makes their work hard to coordinate and deliver efficient services to the patients. They also pointed out that citizens know and understand the challenges medical officers are going through and it has become part of their day to day realities.

The interview with the citizens also indicated many challenges in the delivery of health services. One of the participants stressed that there is still a lot of unfulfilled promises. He stressed that the existence of corruption at the facility is a huge challenge to service delivery.

He pointed out that, regardless of a critical condition a patient may be in, without money to pay the nurses for quick response will render one helpless. In his words, the respondent laments. “There are so many cases of unfulfilled delivery services, a case in point is a pregnant mother, who failed in a health centre here and was referred to Itojo hospital in a critical condition as she approached, the medics, she was asked for money and ignored and ignored until she finally produced the money”. Several scholars including Lipsky (2010) have stressed the way street level bureaucrats imposes their own rules in the delivery of services.

Lipsky (2010) points out how street level bureaucrats bend rules by “developing techniques to salvage service and decision making values within the limits imposed on them by the work structure”. Lipsky observes that these practices are maintained even when they continue to distort the ideal of delivering services. This puts them in the ‘position of manipulating citizens’ as they continue to expect fair treatment. The principal agent theory also points out that the multiple agent analysis which focuses on a vertical chain of principals whereby, the “people” as principal who elect the ‘Congress’ as agent, in turn acts as principal over the government bureaucracy that acts as an agent (Moe, 1991).

In the case of civil servants being agents, the officials bend the rules in their favour. The principal agent relationship further demonstrates that where the Agents have more specialities in what they are doing than the principal, the latter puts them in a more advantageous position and gives them space to pursue their own interests at the principal’s expense. The principal might want to overcome this information asymmetry but getting information has major costs effects and may be difficult. Hence, this forces the principle to pursue his objectives by shaping incentives that are in line with the agent’s interests. The beneficiaries also complained that there is; “lack of poor maternity services, patients not treated well, staffs are

rude especially nurses, the hospital doesn't provide ARVS to all patients. The beneficiaries expressed that there is, "power shortage during road shedding" and that the, "ratio of patients is higher than health workers". Most of the respondents also blamed the staff for "absenteeism, less care for pregnant mothers/patients and late coming". They also pointed out that there is a practice of charging patients illegal fees since the user fees in public hospital were abolished by the government. However, one of the medical personnel blamed citizens for promoting bribery; "we cannot control someone who hides and gives the money to the nurse because there are no cameras in the hospital, how can we do that?" .This shows that there is sluggish delivery of services which force citizens to bribe for the services they are supposed to receive free of charge.

4.2.2. Incorporating residents needs into District Development Planning System (DDPS)

Government officials from different departments of Ntungamo district local government and the Itojo hospital were both interviewed using an open-ended questionnaire and individual in-depth interviews to explain how they incorporated needs and concerns of Ntungamo residents into DDPS and the challenges they face.

The response showed three different approaches on how they tried to incorporate residents into DDPS. Most of the officials believed that stakeholder engagement is the dominant approach being used to incorporate Ntungamo residents into DDPS. This is supported by UNDESA (unpublished) report on local governments in Uganda which emphasises that local units are responsible for incorporating local community issues and concerns into

development[30]. The officials pointed out that electing representatives in the district council (councillors) and the hospital board committees gives a balanced measure to engage stakeholders in the planning process. They also indicated that through this approach, meetings are arranged with various levels of planning ranging from the local councils, public gatherings, and district council and hospital staff meetings. However, the officials pointed out that there is a *"*laxity" in implementing programmes. Some of the officials said that "the money allocated to finance most of the programmes is not enough" while others said "lack of willingness to participate*"* in development programme is still a hug challenge. They further pointed out that "people do not come for the meetings, the meetings are attended by few people mostly women". One of the councillors stressed that there is still a challenge of bringing men on board to fully participate in development programmes. "Men lie behind in terms of participation in government programs due to their unwillingness to take part. There is always been a debate in the council on social problems where we have found out that men spend most of their time in bars drinking". The officials indicated that this has been one of the barriers to the planning and implementation of health programmes that links villages to the hospital.

The development programmes are designed basing on peoples preference. The officials indicated that through meetings and other mechanisms that facilitate democratic participation, people's needs are raised and it is through their preferences that the DDPS base their strategies. The officials stressed that, the fact that people are given a chance of representation at the hospital committee, makes their concerns easy to be heard in the committee during planning process. However, most scholars and institutional reports indicate that representation

[30] Decentralised District Development Planning in Uganda by Henry H. Kellam/UN-DESA, UNDP/OPS. A guide to development planning in local governments in Uganda. http://www.henrykellam.com/reports/UNDESA_uganda_96_99.pdf

alone without collective decision of beneficiaries is not an effective mechanism of serving peoples choices (Ganeva 2006). According to Ganeva (2006), a complete democratic citizenship can be gained not only through the practice of political and civil rights, but can as well be acquired through 'participatory processes and struggles'. On the other hand, most of the officials showed that their efforts are limited by shortage of funds which is beyond their means.

The officials' response also indicated that considering people's levels of income help them to determine how many are able to afford health care services and that this was the reason government abolished user fees in public hospitals. They stressed that most of the local people are poor and cannot afford to pay for services in hospitals. However, the officials stressed that the local government units do not have enough funds and this has proved to be tough in effort to meet their required service delivery target.

4.2.3. Challenges incorporating citizens in DPP

Using structured questionnaires with options of Yes, No, Not sure, Officials were asked whether they faced challenges in incorporating citizens into DPP. The study reveals that a majority (92.0%) of the officials accepted that there are numerous challenges that are faced on a daily basis. On the other hand, 8.0% of the officials do not experience challenges. Therefore, the survey reveals that there are numerous challenges being faced by the officials in trying to incorporate citizens into citizen participation processes. The detailed information of this study is presented in Table 9.

Table 2: Challenges incorporating citizens into DPP

Frequency		Percentage (%)
YES	**23**	**92.0**
NO	**2**	**8.0**
Total	**25**	**100.0**

Source: Author's fieldwork 2013

4.2.4. Overcoming challenges.

Using semi-structured interviews, officials were asked on how they have tried to overcome the challenges being faced in incorporating citizens into citizen participation processes.

4.2.4.1. Radio programmes

The response from officials indicated that community radios have played a big role of informing the local government about the needs and choices of the people. One of the officials said that, "through radio reaction of clients (media intervention-clients can send complaint over radio)". They said that telephone calls or mail messages are the dominant correspondence during these programmes and people are given ample time to express their satisfaction or dissatisfaction.

4.2.4.2. Committed and Service oriented workers

A large number of the hospital officials pointed out that most of the time they are forced to work overtime in order to attend to the needs of patients. Two of the medical personnel responded "Do you think we have time to rest here, I work 24/7 because we don't have

enough staff'. And the second respondent said that working tirelessly they are able to cope with the pressures of service delivery to the over clouding patients with less staff. "By at least we are overworking ourselves such that all people get services". Shortage of staff has dominated the responses from both officials and beneficiaries as one of hindrances to service delivery.

4.2.4.3. Civil society engagement

The response from the officials also revealed that most of the challenges have been overcome through bringing other parties on board. One of the officials said that the burden has been reduced by "involving other civil society organisations in the campaigns" and this has even helped in solving financial problems. This was also discussed in chapter two, where the Egyptian government rendered help for renovation of the decaying health facility at Itojo hospital. The officials have also stressed that the international organisations have helped in "educating citizens and allowing them to express their views through community development meetings". According to the report by An Van Goey (2012) "CSOs in Development Cooperation", civil society organisations are still vital in addressing people's problems in local communities 'and working with governments'. Therefore the concept of networking has also been seen working better in the delivery of services in public health facilities.

4.3. Analysing objective 3: To establish whether or not citizens perceive an improvement in health services as consequence of their participation.

Using an open-ended questionnaire, the researcher interviewed the beneficiaries of Itojo hospital in attempt to find out whether they are happy with the services. The survey conducted

was intended to check beneficiaries view in terms of service satisfaction and awareness of their representation at Itojo hospital. The response from both the beneficiaries and the officials will therefore be a basis for comparison to whether there is an improvement in the delivery of services.

The response from the participants expressed both satisfaction and dissatisfaction with the services being offered at Itojo hospital. Some of the participants said that they are happy with the services they get, while a few of them openly said that they are not happy with the services. One of the participants said that; "coming to this hospital for treatment is like going to the court to hear a ruling about your death sentence". Most of the participants indicated that there is less care for emergency patients like pregnant mothers, HIV/AIDS patients and other serious cases. They indicated that there is no place to lodge a complaint or report their grievances.

Their response also showed that they do not trust hospital suggestion box, saying that they have never seen anyone opening it before. Yet officials stressed that there has been improvement in the type of services being delivered. One of the medical personnel said that the services have improved compared to some few years back when they had only one midwife covering the whole facility; "So you can imagine, some time back, we had only one midwife who would conduct and administers 90 patients, goes to the store to fetch medication and carry out 12 deliveries per day*"*. The officials also stressed improvement in participation of health programmes due to good campaigns against stigma. For instance, officials claim that the fight against stigma has also enabled people to come up and participate in health related programs especially HIV/AIDS. The following section indicates the survey results of beneficiaries' awareness about the services and their satisfaction.

4.3.1. Participants perception about Itojo Hospital Services

Participants were asked using structured questionnaire whether they get services from Itojo hospital. The response from the survey indicates that 87.8% of those who took part agreed that they get services from Itojo hospital. Only 12.2% of the respondents indicate that they do not get services from the hospital. The detailed information of the survey is presented in the Table 2 below.

Table 3: Citizens who get services from Itojo hospital

	Frequency	Percentage (%)
YES	**36**	**87.8**
NO	**5**	**12.2**
Total	**41**	**100.0**

Source: Author's field work 2013

4.3.2. Participants perception on the existence of hospital management committee

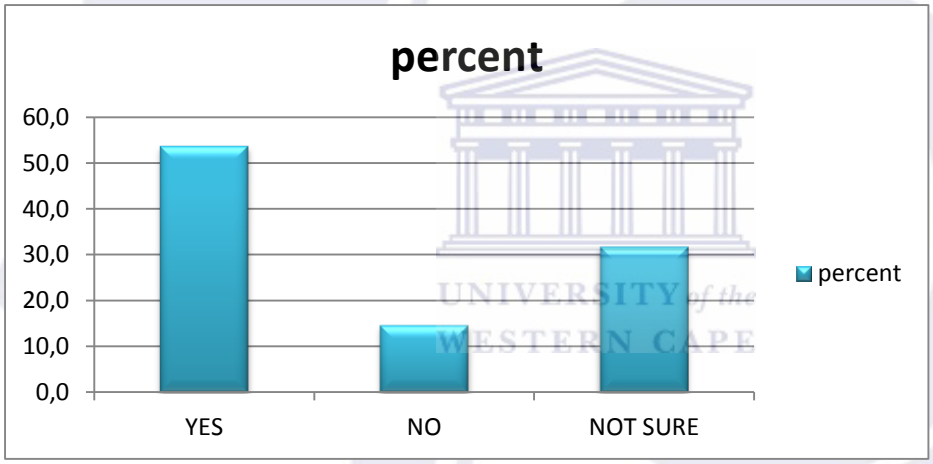
In order to get a clear understanding of the participant's perception, the survey also asked a question on the participant's perception on Itojo hospital management committee. The response from the survey revealed that 53.7% of the participants in this survey knew that the hospital has a management board, while 14.6% do not know about the hospital management committee and 31.7% were not sure about the hospital committee. The survey results are presented in Table 3 and Figure 6.

Table 4: Participants perception on the existence of hospital management committee

Frequency		Percentage (%)
YES	22	53.7
NO	6	14.6
NOT SURE	13	31.7
Total	41	100.0

Source: Author's field work 2013

Figure 6: Participants perception on the existence of hospital management committee



Source: Author's field work 2013

To understand the citizens' satisfaction, a question was further asked if they were happy with the services they get from the hospital. The survey shows that 51.2% of the respondents were happy, while 39.0% were not happy and 9.8% were not sure about the services.

Table 5: Participants who are satisfied with the services

Frequency		Percentage (%)
YES	**21**	**51.2**
NO	**16**	**39.0**
NOT SURE	**4**	**9.8**
Total	**41**	**100.0**

Source: Author's field work 2013

4.3.3. Reasons for improved service delivery

The officials were asked by the researcher about the reasons for improved health service delivery. According to the findings, the reasons for improvement do not deviate away from the principles agitated by the MDG report (2012) discussed in chapter one. From the findings, it is evident that leadership accountability, decentralised services, and non-discriminatory environment have led to the improved service delivery in Itojo hospital. However, some of the participants as argued earlier in the thesis still questions and doubts whether there is proper accountability at Itojo hospital. The following findings as the reasons for improvement were arrived at by the help of semi-structured interviews.

4.3.3.1. Leadership accountability

The responses from the respondents indicate that leadership at the grassroots level has improved tremendously. This concurs with the district scorecard report (2010) that was discussed earlier in this study. The district council leaders demonstrated higher performance in all council and community meetings. The majority of the Sub county councillors'

performances in district councils were very high. According to the findings of the study, one of the respondents in the study replied that the leaders have taken a lead in delivering services to the people; "In one way or another, the leaders owe the people the responsibility to bring services to them and they have in some instances".

Some of the respondents have credited the improvement in leadership on pressures that the leaders faced to fulfil their promises during election campaigns, "It has put pressure on leaders to deliver according to their promises". This is due to the fact that electorates have some kind of pay back through ballot box voting system. After every five year term, local people are permitted by the constitution of Uganda 1995 to vote for their leaders for the next term. This keeps check on the leaders to deliver in order for them to be voted into leadership in the next term. This is related to the principal agent relationship which demonstrates that the principal can also use selective monitoring and punishments to encourage agents to implement activities to achieve these objectives. However, this works better when people have voices and express their dissatisfaction through a free and fair election where there is independent electoral body.

4.3.3.2. Non-discriminatory environment

The participants pointed out that a non-discriminatory environment has also led to the improvement of health service delivery. They further stressed that this has enabled people to attend treatments, meetings, and building health programs as well as taking part in other developmental programs. The respondents also noted that all genders with different status are treated the same. One of the participants acknowledged that "Men and women are treated without discrimination*",* and the another one also said that involvement has reduced stigma,

*"*Involvement of HIV/AIDS positive client in outreach programmes of sensitization thus reducing stigma*"*, and on the non-discriminatory representation, one of participants said that *"*Having different gender representatives at all levels of planning to capture their concerns*"*. In the community programmes, they also noted that they do inclusive outreaches *"*we involve all HIV/AIDS positive patients in our outreach programmes and sensitisation*"*. This is supported by Friedman (1992) who calls for communities to take part in decision-making process. When local people are involved on mutual basis, the success and sustainability of the project is assured as they locally support it as their own.

4.3.3.3. Decentralised services

The study revealed that bringing services closer to the people have solved many challenges that are faced by citizens on an everyday basis. The participants expressed their satisfaction with decentralised services on the basis that they no longer travel long distances to find the services. Some of the participants acknowledged the improvement of service delivery on health centres which are near to the communities, "By bringing services near to the people, for example health centres at sub county level". They also acknowledged that the local government has started to support the establishment of community based organisations "encouraging people to form community based organisations where their voices can be heard". This has done some minimal improvement in the health service delivery. However, respondents complained of shortage of drugs in all the community health centres as discussed earlier in this study.

4.3.4. Suggested means to improve citizen participation in Ntungamo District

Officials' were asked how citizen participation can be improved using open ended questions and in-depth individual interviews. Their responses suggest ways in which public participation in Ntungamo district can be improved. These ways to improve citizen participation are discussed below.

4.3.4.1. Massive sensitisation

The responses from the officials indicate that people are not aware of their rights which therefore raise the concern of empowering such communities.[31] Friedmann (1992) addresses this dilemma as lack of power in both social and political aspects. The officials stressed that there is need for massive sensitisation of communities about their power to influence decisions. One of the officials expressed that there is need for massive sensitization, "Massive sensitisation of people of their rights, roles and responsibilities to the grass root level". Another official believed that participation can be raised through engaging citizens in public participation process. She said, "Involving women, men, youth and people with disabilities in public participation process". Several scholars have also recognised the need for engaging citizens on issues concerning community development. Williams (2007) also calls for citizens to take the centre stage in decision making about the issues that affect their lives. According to Richards et al. (2004), evidence from studies in developing countries suggests that 'locally based' and locally owned decisions are more effective in the long term planning. Involvement of citizens in decision-making process creates ownership and sustainability.

[31] "Local people in deep areas remain local people and that's their name, so without sensitisation, it's hard for them to understand their rights". Participant field work response.

4.3.4.2. Stakeholder engagements

The findings indicate that the majority of the respondents believe that there is still a huge need for stakeholder engagements in all programs that requires local peoples backing to progress. Officials expressed their concern about less awareness of local people to participate in health programs. One of the officials stressed that participation can improve only if they can all parties affected by the problems on board. "Bring people infected and those affected by the problem on board". Another official also lamented that "local people in deep areas remain local people and that's their name, so without sensitisation, it's hard for them to understand their rights*"*. Whereas other officials indicated that people needs to be educated, "masses need to attain good levels of education and being disciplined in everything". This also recognised by Friedman (1992), who observes that communities should have voice and power in decision making. The responses also drew the researcher to observations made in the relationship between agent and the principal. The theory indicates that agents have more specialties in what they are doing than the principal. This puts them in a more advantageous position and gives them space to pursue their own interests at the principal's expense. Therefore overcoming the information asymmetry helps the principal in the process of demanding efficient services.

4.4. Summary of research findings

The provisional findings indicate that citizen participation does not necessarily improve service delivery. Citizen participation is demonstrated by councillors with excellent performance, especially during their sub-county council meetings (see chapter two page 19).Furthermore, the study demonstrates minimal understanding of citizen participation in the services of Itojo hospital. The mechanisms of participation are also mentioned which has

encouraged participation of the citizens in health programs (see chapter four pages 46-49). However, the findings also indicate that this does not reflect in delivery of services. The study witnessed poor delivery of health services and alarming conditions of the hospital facilities.

The provisional findings further indicate that there numerous challenges being faced to enhance service delivery. The survey shows that there are so many cases of unfulfilled delivery ranging from poor administration to shortage of resources. For instance the participants complained of lack of ARVS, power shortage during road shedding, late delivery of drugs from national medical stores, corruption that has led to patients bribing nurses for medical attention, absenteeism of nurses, as well as late coming of nurses to work place. The findings also indicate that the nurses are so rude to patients. Therefore, regardless of citizens' participation these challenges still hamper the delivery of health services in Itojo hospital.

Policy implementation is also still a dilemma. As discussed in the findings of this study, though the government of Uganda abolished cost sharing in public hospitals in 2001, patients still pay for the health services in public hospitals. The response from participants indicates that patients still pay money to fuel ambulances and the hospital generator. This is when the patient is in critical condition and needs to be operated during road shedding[32] of hydro power. Yet the government abolished user fees in 2001 and it is well stated in the policy documents but this means that it only exists on paper. The participants also stressed that there is delay of pain killers when operation is done. They stressed that patients at times after operation find their way to private clinics to buy pain killers after spending two days of waiting for pain killers from hospital nurses. All these findings exposed the weakness of hospital management in the implementation of policy programmes for service delivery.

[32] Itojo hospital faces a major problem of hydroelectricity that is subjected to road shedding. This means that the electricity is not reliable even during the operation of patients.

Lastly, provisional findings indicate that there is minimal improvement of services at Itojo hospital. Some of the participants indicated that they were happy with the services they get compared to some few years back, while a few of them openly said that they are not happy with the services. For example one of the participants lamented; “coming to this hospital for treatment is like going to the court to hear a ruling about your death sentence”. Furthermore, most of the participants indicated that there is less care for emergency patients like pregnant mothers, HIV/AIDS patients and other serious cases. They indicated that there is no place to lodge a complaint or report their grievances. Their response also showed that they do not trust hospital suggestion box, saying that they have never seen anyone opening it before. Yet officials stressed that there has been improvement in the type of services being delivered compared to some years back. For example, one of the medical personnel recalled; “so you can imagine, some time back, we had only one midwife who would conduct and administers 90 patients, goes to the store to fetch medication and carry out 12 deliveries per day”. Therefore, there has been some improvement though there is still more room for improvement.

CHAPTER 5

CITIZEN PARTICIPATION TOWARDS-COMMUNITY DEVELOPMENT ORIENTED PROGRAMMES: CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

From the conceptual point of view indicated in chapter one, the local people who are the beneficiaries in this case still struggle to get their health care entitlements and their voices are still not heard. Health services are still in a poor condition and some of the citizens continue to suffer because of service delivery issues. This was the case revealed in the study discussed in chapter four. The people's voices and challenges of service delivery are still not properly addressed. The provisional findings indicate that the beneficiaries of Itojo hospital have not been able to lodge any complaint though the services seem not to be good. This is due to absence of proper procedures in incorporating citizens in a participatory process. The beneficiaries were also not aware of the hospital management committee which signifies less participation of the citizens in the hospital management. Therefore, the provisional research findings confirms the hypothesis; if communities are not involved in the decision making process at local level, then the delivery of services would remain top-down and there will be poor services at the local level as indicated in section 1.4 chapter one. Thus, the challenges facing local communities due to poor service delivery will still continue if people are not informed of their role in developmental programs.

In fact, it will be hard for the government to implement and sustain developmental programmes if people are not given more influence to act as foreseers. In a development perspective, the knowledge which is locally owned works better than the enforced knowledge due to a sense of belonging and ownership (Richards et al. 2004). Enforced health service

delivery programmes will make people feel distanced from making or contributing to decisions made and they will not have concern for the success of the program.

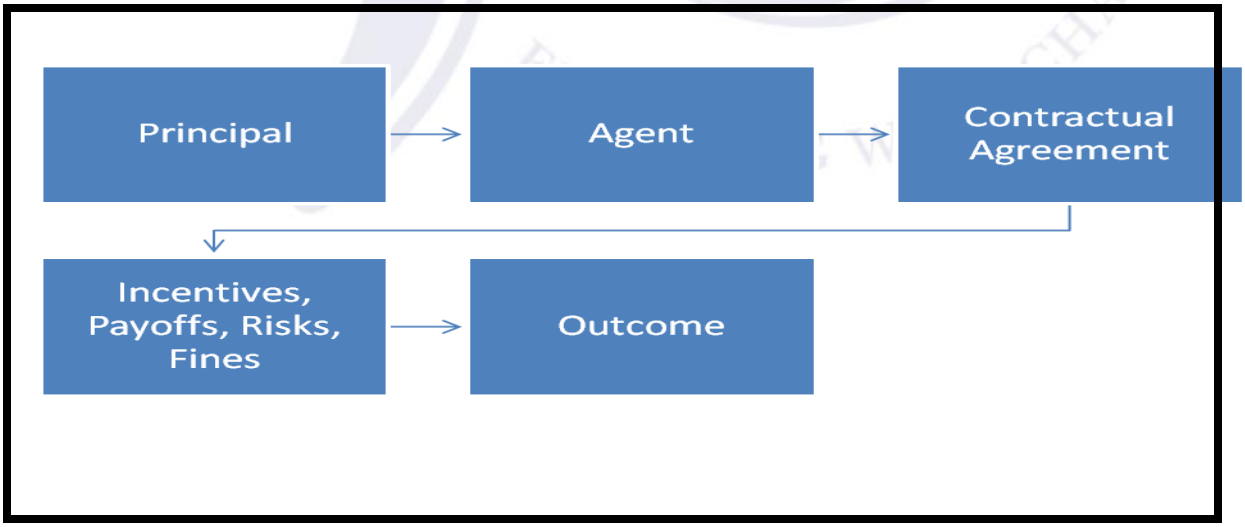
Chapter two of this study has also shown how the government of Uganda ambitiously carried out administrative reforms to promote service delivery at lower units of government. This was carried out through devolution of power from the central government to local government. The planning system at the local government level is very short thus it does not favour long term investments in health. The government further carried out health reforms for example, greater emphasis on primary health care, abolition of user fees in public hospitals, expansion of rural lower health facilities, provision of subsidies to private and non-profit sector, introducing sub district structure to mention a few. However, the chapter also indicates that health services in these sub district structures are still poor due to poor state of the hospital facility, congestion of patients in wards, few medical personnel and lack of medicine in the hospital.

Chapter three has indicated different ways in which citizen participation can improve the health service delivery and how best it can be implemented to promote sustainable development. It has stressed the need for local people to take part in decision making processes, and this is also clearly indicated in the health system framework. The health system framework has also indicated how a set of a system 'system building blocks' is fundamental in achieving the overall goals/outcome.

Relating the findings of the study to the principal agent theory, it has been observed in this research that the principal can also use selective monitoring and punishments to encourage

agents to implement activities in achieving his objectives. Local leaders especially district councillors have exhibited high level of performance in fear of losing their council seats in other upcoming elections (As indicated in chapter two page 19). Voting the local leaders into the council is demonstrated as the contractual agreement between the agent and the principal. This prompts the agent to put the incentives as vote of no confidence or voting them out after they have completed a five year term. Then the outcome is the services that will be delivered as a result of the contractual agreement. However, this theory posits that the agents have more specialities in what they are doing than the principal. This puts them in a more advantageous position and gives them the space to pursue their own interests at the expense of the principal. The principal might want to overcome this information asymmetry but has major cost effects and might be difficult. This as a result forces the principle to pursue his objectives by shaping incentives that are in line with the agent's own self-interests. The figure 10 demonstrates this relationship between the principal and the agent.

Figure 10: Contractual Relationship



Source: Author's Construct 2013

In terms of community development strategies, the two parties should be guided by certain principals and each party must have a voice that enforces such principals. In this situation as evidenced in the study, how will the principal enforce such incentives when he has got a limited voice? In other wards how will he get the platform when he is overshadowed by the autocratic forms of leadership? The study's findings reveal that there is less awareness of the beneficiaries at the grassroots level. This gives clear evidence that local people are not wholly enlightened to participate in development programs. Focusing on the insights of chapter one, achieving the objectives of the Alma Ata Declaration and the Millennium development goals seem to be still a milestone. It can only be possible when local communities are given a chance to dictate their own destiny.

5.2. Recommendations

The study should be revisited with in-depth investigation

Considering the complexity of this study and the limited funds to the researcher, the study could not be investigated in depth. Therefore, the researcher recommends that this study should be revisited with the necessary in-depth investigation. The current study has not been able to fully cover a wide range of area also due to short time frame.

Local government should review capacity building programmes strategy for all workers

There is a need for capacity building programs for officials/councillors to fully incorporate local people into citizen participation programs. The findings have shown that there are so many challenges being faced by the officials on how to incorporate local people into integrated development programs. Capacity building programs will provide them with skills on how to engage citizens in decision making processes.

Local people should form community based organisations that discuss/focus on their welfare.

Community based organisations work better with local communities. This is because of day-today relations between the community and the organisation workers. The closeness of the organisation enables people to come out of their shells and speak out on certain issues that face their lives. Community based organisations can as well work as a link between the community and the local government.

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