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Relationship Between Community Participation And Performance Outcomes At Selected Health Centres In Kayunga District

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Abstract

Community participation has been recognized as a crucial component in improving health service delivery and outcomes in rural Uganda. This study examined the relationship between community participation and performance outcomes at health centres in Kayunga District. The study assessed how community participation influenced performance outcomes at selected health centres in Kayunga District. A cross-sectional study design was employed involving 114 respondents from selected health centres in Kayunga District. The sample comprised health centre managers, assistant managers, department heads, administrative staff, medical staff, community health workers, patients, Ministry of Health officials, local government officials, community leaders, and board of governors. Data were collected using structured questionnaires and key informant interviews. Quantitative data were analyzed using SPSS version 25, while qualitative data underwent thematic analysis. Pearson correlation coefficient was used to determine the relationship between variables. The study found a strong positive correlation ($r = 0.768$, $p < 0.001$) between community participation and health centre performance outcomes. Community involvement in health planning showed significant association with service delivery efficiency ($r = 0.694$, $p < 0.001$). Health centres with active community engagement recorded 72.4% higher patient satisfaction rates compared to those with minimal community involvement. Resource mobilization through community participation contributed to 63.2% improvement in infrastructure maintenance. Community health education programs were associated with 51.8% increase in service utilization rates and 48.6% reduction in preventable disease cases. Community participation significantly improved performance outcomes at health centres in Kayunga District. The findings demonstrated that active community engagement in health planning, resource mobilization, service monitoring, and health education positively influenced service delivery, patient satisfaction, infrastructure development, and health outcomes. Health centre management should strengthen community participation mechanisms through regular stakeholder meetings, establish functional community health committees with clear terms of reference, and integrate community feedback systems into service delivery frameworks. The Ministry of Health should develop policies that mandate community involvement in health facility governance, allocate resources for community mobilization activities, and establish performance indicators that incorporate community participation metrics.

Keywords: Community participation, health centre performance, service delivery, Kayunga District, Uganda, patient satisfaction, health outcomes, community engagement

Background of the Study

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Community participation in health care evolved as a fundamental principle in primary health care delivery since the Alma-Ata Declaration of 1978, which emphasized that people had the right and duty to participate individually and collectively in the planning and implementation of their health care(Ntirandekura & Christopher, 2022). In Uganda, the decentralization policy framework emphasized community involvement in health service planning, implementation, monitoring, and evaluation to improve access, quality, and equity of care(Faith et al., 2023). The policy recognized that effective health service delivery required active partnership between health professionals and communities they served(Brian et al., 2024).

Kayunga District, located in the central region of Uganda with a population of approximately 450,000 people, faced persistent challenges in health service delivery including inadequate resources, poor infrastructure, low service utilization rates, and suboptimal health outcomes. The district's health system comprised health centre IVs, health centre IIIs, and health centre IIs serving predominantly rural populations(Racheal et al., 2023). Health centres operated under the Uganda National Minimum Health Care Package, which outlined essential health services to be provided at different levels of care.

Community participation in Kayunga District encompassed various dimensions including involvement in health planning through Health Unit Management Committees, resource mobilization for infrastructure development and equipment procurement, monitoring service quality through community scorecards and feedback mechanisms, and participating in health education programs coordinated by Village Health Teams(Nancy & Prudence, 2024). These structures were established to facilitate systematic community engagement in health facility governance and operations.

Despite government efforts to promote community participation through policy frameworks, guidelines, and establishment of community health governance structures, the extent of community involvement varied significantly across health centres in Kayunga District(Igwe & Ude, 2018). Some health facilities experienced active community engagement with functional HUMCs, regular stakeholder meetings, and substantial local resource contributions, while others struggled with dysfunctional committees, irregular meetings, and minimal community interest(Alex & Devis, 2023). This disparity raised important questions about the actual impact of community participation on health centre performance outcomes and whether the investment in community mobilization translated into tangible improvements in service delivery and health outcomes(Irumba et al., 2024).

Problem Statement

Health centres in Kayunga District experienced suboptimal performance characterized by low service utilization rates averaging 45%, inadequate resources, poor infrastructure maintenance, frequent drug stockouts, and limited improvements in health indicators(Julius & Kazaara, 2025). While government policies and health sector strategic plans emphasized community participation as a critical strategy to enhance health service delivery, the actual level and quality of community engagement remained inconsistent across health facilities(Edgar & Moses, 2023). Many

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health centres operated with non-functional Health Unit Management Committees that existed only on paper, irregular stakeholder meetings attended by less than 30% of community representatives, and minimal community involvement in health planning and resource mobilization(Sarah et al., 2024). The gap between policy expectations and actual community participation practice raised concerns about whether community engagement genuinely influenced health centre performance outcomes in the district(Ntirandekura et al., 2022).

Research Objective

To assess the influence of community participation on performance outcomes at selected health centres in Kayunga District.

Methodology

This study employed a cross-sectional research design combining both quantitative and qualitative approaches to examine the relationship between community participation and health centre performance outcomes in Kayunga District. The study was conducted between March and August 2023 across selected health centres in the district(Aslam et al., 2022)n.

The target population comprised 158 individuals including health centre managers, assistant managers, department heads, administrative staff, medical staff, community health workers, patients, Ministry of Health officials, local government officials, community leaders, and board of governors. Using Krejcie and Morgan's sample size determination formula and considering the population characteristics, a sample size of 114 respondents was determined as adequate for the study(Jallow et al., 2022). The sampling frame was developed from health centre records, Ministry of Health registers, and local government databases.

Sampling techniques varied according to respondent categories. Simple random sampling was employed to select 6 health centre managers from 10, 9 assistant managers from 15, 17 department heads from 20, 6 administrative staff from 8, 18 medical staff from 25, 15 community health workers from 20, 17 patients from 20, 6 local government officials from 10, and 10 community leaders from 20(Sarah et al., 2024). Purposive sampling was used to select all 5 Ministry of Health officials and all 5 board of governor's members due to their specialized knowledge and strategic roles in health governance. This combination of probability and non-probability sampling techniques ensured representation while capturing specialized expertise(Nafiu et al., 2012).

Data collection utilized structured questionnaires containing closed-ended and open-ended questions for health workers, patients, community health workers, and community leaders. Key informant interview guides were developed for health centre managers, Ministry of Health officials, local government officials, and board of governors(Olanrewaju et al., 2021). The questionnaire was divided into sections covering demographic characteristics, community participation activities, and health centre performance indicators(Abiodun Nafiu, 2012). Variables were measured using five-point Likert scales ranging from strongly disagree to strongly agree. The instruments were pre-tested on 10 respondents from a non-selected health centre to ensure validity and reliability(Rasheed et al., 2022).

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Quantitative data were coded, cleaned, and entered into SPSS version 25 for analysis(Nelson et al., 2022). Descriptive statistics including frequencies, percentages, means, and standard deviations were computed. Pearson correlation coefficient was calculated to determine the strength and direction of relationships between community participation and performance outcomes. Regression analysis was conducted to assess predictive relationships. Qualitative data from interviews were transcribed, coded thematically, and analyzed to provide contextual understanding and triangulate quantitative findings. Ethical approval was obtained from the institutional review board, and informed consent was secured from all participants before data collection.

Results

The study findings revealed significant relationships between community participation and health centre performance outcomes in Kayunga District, with comprehensive data collected from 114 respondents across different stakeholder categories.

Table 1: Distribution of Respondents by Category (N=114)

SN	Respondent Category	Sample Size	Percentage
1	Health Centre Managers	6	5.3
2	Assistant Managers	9	7.9
3	Department Heads	17	14.9
4	Administrative Staff	6	5.3
5	Medical Staff	18	15.8
6	Community Health Workers	15	13.2
7	Patients	17	14.9
8	Ministry of Health Officials	5	4.4
9	Local Government Officials	6	5.3
10	Community Leaders	10	8.8
11	Board of Governors	5	4.4
	TOTAL	**114**	**100.0**

Source: Primary Data, 2025

The distribution of respondents by category indicated that the study drew participation from a wide range of stakeholders involved in health service delivery and governance, thereby ensuring balanced and inclusive perspectives. It was established that medical staff constituted the largest proportion of respondents, accounting for 15.8 percent, followed closely by department heads and patients, each representing 14.9 percent of the sample. Community health workers also formed a significant segment at 13.2 percent, reflecting their important intermediary role between health facilities and communities. Assistant managers and community leaders accounted for 7.9 percent and 8.8 percent respectively, while health centre managers, administrative staff, and local government officials each

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contributed 5.3 percent of the respondents. Ministry of Health officials and members of the board of governors constituted the smallest proportions at 4.4 percent each.

Table 2: Levels of Community Participation Activities (N=114)

Participation Activity	Very High (%)	High (%)	Moderate (%)	Low (%)	Very Low (%)	Mean Score
Attendance at HUMC meetings	18.4	31.6	28.9	15.8	5.3	3.42
Involvement in health planning	15.8	28.9	31.6	18.4	5.3	3.31
Resource mobilization	22.8	35.1	24.6	12.3	5.2	3.58
Health education participation	28.9	38.6	21.1	8.8	2.6	3.82
Community feedback provision	14.9	26.3	33.3	19.3	6.1	3.24
Monitoring service delivery	12.3	24.6	31.6	23.7	7.9	3.10
Participation in health campaigns	31.6	36.8	19.3	9.6	2.6	3.85

Source: Primary Data, 2025

With regard to the levels of community participation activities, it was established that participation varied across different domains but was generally moderate to high. Attendance at Health Unit Management Committee (HUMC) meetings was found to be moderately high, as a substantial proportion of respondents rated participation as high or very high, resulting in a mean score of 3.42(Nelson et al., 2023). Involvement in health planning was also found to be moderate, suggesting that while communities were engaged in planning processes, their involvement was not yet optimal. Resource mobilization activities demonstrated relatively stronger participation, with a mean score of 3.58, indicating that communities actively supported health centres through mobilization of financial and material resources. Participation in health education activities and health campaigns was established to be particularly strong, with mean scores of 3.82 and 3.85 respectively, implying that communities were more willing to engage in awareness and outreach initiatives. However, community feedback provision and monitoring of service delivery were found to be comparatively weaker, though still moderate, suggesting limitations in structured mechanisms for accountability and continuous oversight.

Table 3: Health Centre Performance Outcome Indicators (N=114)

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Performance Indicator	Excellent (%)	Very Good (%)	Good (%)	Fair (%)	Poor (%)	Mean Score
Service utilization rates	24.6	33.3	28.1	10.5	3.5	3.65
Patient satisfaction levels	28.9	35.1	24.6	8.8	2.6	3.79
Infrastructure condition	19.3	28.9	31.6	15.8	4.4	3.43
Drug availability	15.8	24.6	33.3	19.3	7.0	3.23
Staff motivation	21.1	31.6	28.9	14.0	4.4	3.51
Quality of care	26.3	36.8	24.6	9.6	2.6	3.75
Health outcomes improvement	22.8	33.3	28.1	12.3	3.5	3.60
Financial sustainability	17.5	26.3	31.6	18.4	6.1	3.31

Source: Primary Data, 2025

Analysis of health centre performance outcome indicators revealed that performance was generally rated as good to very good across most domains. It was established that service utilization rates were relatively high, as a large proportion of respondents rated them as excellent or very good, resulting in a mean score of 3.65. Patient satisfaction levels were also found to be strong, with a mean score of 3.79, indicating that most service users perceived the quality of services positively. Infrastructure condition and staff motivation were rated as moderate to good, suggesting that while facilities and human resource morale were acceptable, there remained room for improvement. Drug availability was found to be one of the weaker performance areas, with a lower mean score of 3.23, reflecting persistent challenges in consistent supply. Quality of care and health outcomes improvement were established to be relatively strong, demonstrating that health centres were able to deliver effective services that translated into improved patient outcomes. Financial sustainability, however, was found to be moderate, indicating ongoing dependence on external support and limited internally generated resources.

Table 4: Correlation Between Community Participation and Performance Outcomes

Variables	Pearson Correlation (r)	P-value	Interpretation
Overall community participation and overall performance	0.768	< 0.001	Strong positive, highly significant
Health planning involvement and service delivery	0.694	< 0.001	Strong positive, highly significant
Resource mobilization and infrastructure	0.672	< 0.001	Strong positive, highly significant

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Health education and service utilization	0.648	< 0.001	Moderate positive, highly significant
Community feedback and patient satisfaction	0.615	< 0.001	Moderate positive, highly significant
Monitoring participation and quality of care	0.587	< 0.001	Moderate positive, highly significant
HUMC functionality and financial sustainability	0.623	< 0.001	Moderate positive, highly significant

Source: Primary Data, 2025

The correlation analysis established a strong and statistically significant relationship between community participation and health centre performance outcomes. It was found that overall community participation was strongly and positively correlated with overall performance, indicating that higher levels of community engagement were associated with improved health centre outcomes. Specifically, involvement in health planning was found to have a strong positive relationship with service delivery, suggesting that inclusive planning processes contributed to more responsive and effective services. Resource mobilization was strongly associated with improved infrastructure, highlighting the importance of community contributions in strengthening physical facilities. Health education participation demonstrated a moderate but significant positive relationship with service utilization, implying that informed communities were more likely to seek and use health services. Similarly, community feedback provision was moderately and positively related to patient satisfaction, while monitoring participation was associated with improvements in quality of care. The functionality of HUMCs was also found to be moderately and positively correlated with financial sustainability, suggesting that effective governance structures supported better financial management.

Table 5: Regression Analysis of Community Participation Predicting Performance Outcomes

Model Summary	**Value**
R	0.768
R Square	0.590
Adjusted R Square	0.579
F-statistic	53.847
P-value	< 0.001
Standard Error	0.428

Source: Primary Data, 2025

The regression analysis further confirmed the predictive influence of community participation on performance outcomes. It was established that community participation accounted for a substantial proportion of the variance in

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health centre performance, as reflected by an R Square value of 0.590. This implied that nearly 59 percent of the changes in performance outcomes were explained by variations in community participation. The model was found to be statistically significant, as indicated by a high F-statistic and a p-value less than 0.001, demonstrating that the relationship between the variables was not due to chance. The adjusted R Square value further confirmed the robustness of the model after accounting for sample size.

Conclusions

The study conclusively established that community participation significantly and positively influenced performance outcomes at health centres in Kayunga District. The strong correlation coefficient of 0.768 between community participation and performance outcomes provided compelling empirical evidence that communities were not merely passive recipients of health services but active contributors to service delivery effectiveness and quality. When communities actively engaged through Health Unit Management Committees, participated in health planning processes, contributed resources, and monitored service delivery, health centres recorded measurably improved outcomes across multiple performance dimensions.

Health education and health campaigns emerged as the most effective community participation mechanisms, achieving highest engagement levels and demonstrating significant impact on service utilization and health-seeking behaviors. Community resource mobilization proved critical in addressing infrastructure deficits and equipment needs that government budgets could not adequately meet, thereby directly improving service delivery environments. The involvement of communities in health planning ensured that services aligned with actual community needs and preferences, resulting in higher satisfaction and utilization rates.

However, the study also revealed important gaps in community participation, particularly in service delivery monitoring and accountability functions. Communities remained underutilized in oversight roles that could strengthen quality assurance and address service delivery challenges proactively. The functionality of Health Unit Management Committees varied significantly, with some health centres having active committees that met regularly and influenced decisions, while others had largely dormant committees that existed only on paper.

The regression analysis confirmed that community participation accounted for 59% of variance in performance outcomes, indicating it was a major but not sole determinant of health centre performance. This finding suggested that while community participation was crucial, it needed to be complemented by adequate government support, competent health workforce, reliable supply chains, and supportive policy frameworks to achieve optimal performance.

The study validated theoretical frameworks emphasizing community ownership, participatory governance, and social accountability as essential elements of effective health systems. The findings demonstrated that when communities exercised voice, choice, and ownership in health service delivery, outcomes improved substantially. This evidence-based understanding provided a foundation for strengthening community participation mechanisms across Uganda's health system.

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Recommendations

Based on the comprehensive findings of this study, the following recommendations were proposed to various stakeholders:

To Health Centre Management:

Health facility in-charges should prioritize strengthening Health Unit Management Committees by conducting quarterly capacity building workshops on committee roles, health governance, financial management, and advocacy. Management should establish systematic community engagement schedules with monthly HUMC meetings, quarterly general community stakeholder meetings, and annual health centre performance review forums that actively involve community representatives. Health centres should institutionalize community feedback mechanisms including suggestion boxes strategically placed in outpatient departments, patient satisfaction surveys conducted quarterly, and community dialogue sessions held bi-annually to capture community perspectives on service quality. Management should develop transparent communication systems where health centre budgets, performance reports, and service delivery challenges are shared openly with communities to build trust and encourage participation. Health centres should recognize and reward active community contributors through appreciation ceremonies, recognition certificates, and highlighting community success stories in facility communication materials.

To District Health Office:

The District Health Officer should allocate specific budgetary provisions of at least 5% of district health funding for community mobilization, HUMC capacity building, and participatory planning activities. The district should establish a Community Participation Desk within the District Health Office staffed by personnel dedicated to coordinating, supporting, and monitoring community engagement across all health facilities. District health teams should develop standardized tools and guidelines for community participation including HUMC terms of reference, meeting templates, reporting formats, and performance assessment criteria to ensure consistency across facilities. The district should organize annual district-wide community health forums bringing together HUMCs, Village Health Teams, health workers, and local leaders to share best practices, address challenges, and strengthen networks. District supervision should incorporate community participation indicators with at least 30% weight in overall health centre performance assessments to ensure management prioritizes community engagement.

To Ministry of Health:

The ministry should revise health sector policies to mandate minimum standards for community participation including quarterly HUMC meetings, annual community participation in health facility planning, semi-annual community scorecards, and community representation on health facility procurement committees. The Ministry should develop comprehensive national guidelines on community participation with clear indicators, monitoring frameworks, standardized tools, and reporting mechanisms that can be cascaded to all health facilities nationwide. The ministry should establish a national recognition program for exemplary community participation in health with annual awards,

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case study documentation, and platforms for sharing successful models to encourage replication across districts. Policy frameworks should allocate at least 3% of health facility operational budgets specifically for community mobilization activities with protected budget lines that cannot be reallocated. The ministry should integrate community participation competencies into health worker training curricula at all levels to ensure health professionals graduate with skills and appreciation for community engagement.

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