METROPOLITAN INTERNATIONAL UNIVERSITY

GOOD GOVERNANCE AND PERFORMANCE OF HEALTHY CENTRES IN KAYUNGA DISTRICT. A CASE STUDY OF SELECTED HEALTHY CENTRES IN KAYUNGA DISTRICT

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23/HD01/MPA/KC

A DISSERTATION SUBMITTED TO THE SCHOOL OF MANAGEMENT SCIENCE IN PARTIAL FULFILLEMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER'S DEGREE IN PUBLIC ADMINISTRATION (MPA) OF METROPOLITAN INTERNATIONAL UNIVERSITY

JANUARY, 2026

Received: 20.03.2026 **Accepted: 25.03.2026** **Published on: 30.03.2026**

Corresponding: Author: journals.miu.ac.ug

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

DECLARATION

I **Kusaasira Racheal**, declare that this Dissertation with title "good governance and performance of healthy centres in Kayunga district. A case study of selected healthy centres in Kayunga district" is my original work and has not been submitted for any award at any academic institution.

Signed: ……. **Date: …….**

REG NO: 23/HD01/MPAM/KC

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

APPROVAL

This is to confirm that this Dissertation on “good governance and performance of healthy centres in Kayunga district.” has been done under my supervision on a university supervisor.

Signature: ……. **Date: …….**

KAMUGISHA NELSON

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Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

DEDICATION

This dissertation is dedicated to my family for their unwavering support, encouragement, and sacrifices throughout my academic journey. I also dedicate this work to my supervisor for the invaluable guidance and mentorship provided during the course of this study. Finally, this dissertation is dedicated to all public administrators and health practitioners whose commitment to good governance continues to improve service delivery in Uganda's health sector.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

ACKNOWLEDGEMENT

I express my sincere gratitude to the Almighty God for the strength, wisdom, good health, and guidance that enabled me to successfully complete this dissertation. Without His grace, this academic journey would not have been possible. I am deeply indebted to my supervisor, Mr. Kamugisha Nelson, for his professional guidance, patience, constructive criticism, and continuous encouragement throughout the research process. His scholarly input and commitment greatly enriched the quality of this study. I extend my appreciation to the lecturers and staff of the School of Management Science, Metropolitan International University, for equipping me with the knowledge and skills that formed the foundation of this research. I am also grateful to the university administration for providing a supportive academic environment conducive to learning and research. Special thanks go to the management and staff of the selected health centres in Kayunga District for their cooperation, time, and willingness to provide the necessary information that made this study possible. I also appreciate the Kayunga District Health Office for granting permission and support during data collection. Finally, I sincerely thank my family, friends, and colleagues for their moral support, encouragement, and understanding throughout my studies. Their unwavering support and belief in me were a constant source of motivation.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

LIST OF ABBREVIATIONS

ANC - Antenatal care

FY - Fiscal Year

HIMS - Health Information Management System

HIV - Human Immunodeficiency Virus

HRH - Human Resources for Health

ICCM - Integrated community case management

IGG - Inspectorate of Government

KCCA - Kampala Capital City Authority

MCH - Maternal and child health

MDGs - Millennium Development Goals

MIU - Metropolitan International University

MOH - Ministry of Health

MPA - Master's Degree in Public Administration

NGOs - Non-Governmental Organizations

OECD - Organization for Economic Cooperation and Development

P-A - Principal-Agent

SARA - Service Availability and Readiness Assessment

SDGs - Sustainable Development Goals

SPSS - Statistical Package for Social Sciences

UBOS - Uganda Bureau of Statistics

UNAIDS - Joint United Nations Programme on HIV/AIDS

UNICEF - United Nations Children's Fund

WHO - World Health Organization

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

Abstract

The study examined the relationship between good governance practices and the performance outcomes of selected health centres in Kayunga District, Uganda. Specifically, the study assessed the influence of community participation, accountability mechanisms, and resource availability on health centre performance. The study was guided by the Principal–Agent Theory and Institutional Theory. The Principal–Agent Theory was applied to explain how accountability mechanisms such as supervision, transparency, and reporting aligned the actions of health workers (agents) with the expectations of government and communities (principals). Institutional Theory was used to explain how adherence to established governance norms, rules, and procedures shaped organizational behavior and performance within public health facilities. The study adopted a descriptive cross-sectional research design and employed a mixed-methods approach. Quantitative data were collected using structured questionnaires administered to health workers, health centre managers, and members of health unit management committees, while qualitative data were obtained through key informant interviews. A sample of 114 respondents was selected using stratified and simple random sampling techniques. Data were analyzed using SPSS, employing descriptive statistics, Pearson correlation, and regression analysis, while qualitative data were analyzed thematically. Findings on the first objective revealed a strong positive relationship between community participation and health centre performance ($r = 0.716$, $p < 0.01$). Community involvement in planning, feedback meetings, and decision-making significantly improved service utilization, patient satisfaction, and responsiveness of health services. Regarding the second objective, the study found a significant positive relationship between accountability mechanisms and performance outcomes ($r = 0.684$, $p < 0.01$). Facilities with clear reporting systems, regular audits, and transparent financial practices recorded better service delivery, improved staff discipline, and enhanced public trust. For the third objective, results indicated a positive and significant relationship between resource availability and health centre performance ($r = 0.702$, $p < 0.01$). Adequate staffing levels, consistent availability of essential medicines, and functional infrastructure were found to significantly enhance outpatient attendance, maternal health service utilization, and immunization coverage. The study concluded that good governance practices played a critical role in enhancing the performance of health centres in Kayunga District. Community participation, accountability, and resource availability were mutually reinforcing governance dimensions that significantly influenced service delivery outcomes. Strengthening governance structures was therefore essential for improving efficiency, effectiveness, and equity in public health service provision. The study recommended that the Ministry of Health and district authorities strengthen community participation platforms, institutionalize accountability mechanisms through routine audits and transparent reporting, and ensure adequate allocation and maintenance of essential health resources.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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CHAPTER ONE

INTRODUCTION

1.0 Introduction

Good governance which entailed responsible, accountable and allocation of public resources has increasingly become an important factor impacting the performance of healthcare facilities(Lydia, Ariyo, et al., 2023). Extensive research had established a strong positive correlation between adherence to principles of good governance and improved service delivery outcomes within the health sector. For instance, a study conducted in eight African countries by World Health Organization in 2019 found that healthcare centers applying concepts of participation, rule of law, transparency, responsiveness, equity, effectiveness and efficiency, consensus orientation and accountability registered on average 25% higher patient satisfaction scored and 9% higher facility infrastructure scores compared to counterparts with weak governance practices (WHO, 2019). As the cornerstone of decentralized healthcare in Uganda, lower level health centers serving at the grassroots were expected to spearhead attainment of national health targets through exemplary stewardship and community involvement(Edgar & Moses, 2023). However, according to the Ministry of Health annual sector performance report for FY2019/20, only 56% of all health center IVs and III in the country were classified as providing "good" quality of care with the rest exhibiting various governance and administrative challenges impacting service delivery (MOH, 2020). In Kayunga district located in Central Uganda, statistics from the District Health Office indicate that out of the 22 government-run health centers, only 8 (36.4%) met the minimum standards of infrastructure, staffing levels, medicines availability and community linkages over the two financial years of 2018/19 and 2019/20 a performance significantly below the national average(Faith et al., 2023).

1.1 Background of the study

Good governance had increasingly taken center stage globally as a vital determinant of sustainable development across all sectors(Sarah & Audrey, 2024). At the worldwide level, international conventions and declarations over the past three decades had consistently stressed on the importance of upholding principles such as accountability, participation, transparency, rule of law and responsiveness in management of public resources and service delivery(Gracious, 2023). For example, the 2030 Agenda for Sustainable Development adopted by United Nations member states in 2015 acknowledges that attainment of the 17 Sustainable Development Goals including goal 3 on ensuring healthy lives and promoting well-being for all at all ages was contingent on entrenching robust governance standards within national institutions and systems(Alex et al., 2024).

Regionally, the commitment to implement national health strategies founded on principles of good governance is articulated through various policies and frameworks of the African Union. The 2019-2030 Framework on Sustainable Development in Africa highlights that consolidating core governance tenets was integral to addressing the perennial

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

health challenges facing many countries on the continent(Christopher, Moses, et al., 2022). At the East African regional bloc level, the East African Community Health Policy adopted in 2010 urged partner states to guarantee transparency, equity, community ownership and efficient resource allocation within their healthcare systems as a pathway to better population wellness(Ntirandekura & Friday, 2022).

In Uganda specifically, the 1995 Constitution and all subsequent National Development Plans acknowledge good governance as the bedrock for sustainable socioeconomic progress(Jul et al., 2024). The Third National Development Plan prioritized strengthening of transparency, accountability, participation and ethics across public institutions including local governments and agencies. In line with the decentralized governance framework, district local governments had the mandate of overseeing healthcare delivery through operationalization of relevant laws, regulations and standards with the goal of increasing the population's access to equitable and quality services(Kazaara & Nancy, 2025). Specifically, the 2016 Uganda National Minimum Health Care Package mandates lower level health facilities like health centers to embrace standards of community involvement, financial reporting, infrastructure management and regular stakeholder planning meetings aimed at enhancing performance.

1.1.1 Historical Background

Globally, scholarly discourse on good governance and service delivery had increasingly emphasized ethical leadership, accountability, transparency, and participation as critical determinants of public sector performance(Ntirandekura, Friday, et al., 2022). Since the early 2000s, governance debated shifted from philosophical foundations to empirical and sector-specific analyses, particularly in health systems (Saif et al., 2019). By the post-2020 period, international institutions such as the World Bank and the World Health Organization consistently demonstrated that governance mechanisms especially transparency in resource allocation, community participation, and institutional accountability had significantly influenced health system efficiency, equity, and quality of care (World Bank, 2020; WHO, 2021). Recent global studies confirmed that countries with strong governance frameworks experienced improved health outcomes, better utilization of public health resources, and enhanced trust in public institutions (OECD, 2020). These studies reinforced the notion that good governance was not merely a normative ideal but a measurable contributor to improved performance of health facilities worldwide (UNDP, 2022).

In Africa, the historical trajectory of governance and service delivery had been shaped by colonial legacies, post-independence institutional fragility, and evolving decentralization reforms. By 2020 and beyond, empirical research increasingly linked weak governance structures to inefficiencies in health service delivery, particularly at sub-national levels(Faridah et al., 2023). Studies conducted across Sub-Saharan Africa indicated that corruption, limited citizen participation, and weak accountability mechanisms had constrained health centre performance and access to essential services (AfDB, 2020; Transparency International, 2021). Conversely, countries that implemented governance

Received: 12.03.2026 Accepted: 16.03.2026 Published on: 30.03.2026

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

reforms including community oversight, performance-based financing, and strengthened local accountability recorded notable improvements in primary healthcare delivery (UNECA, 2021). These findings underscored governance as a central factor in addressing persistent health system challenges across the continent.

Within East Africa, governance reforms gained momentum following regional decentralization and public sector reforms aimed at improving service delivery outcomes(David et al., 2023). By the post-2020 period, studies from Kenya, Tanzania, and Rwanda demonstrated that good governance practices at local government levels positively influenced health centre functionality, staff motivation, and patient satisfaction (EAC Secretariat, 2021). Research showed that transparent budgeting, participatory planning, and effective supervision mechanisms enhanced the performance of lower-level health facilities, particularly in rural districts (Kiplagat et al., 2020; Musoke et al., 2022). These regional experiences provided comparative evidence that governance quality at the grassroots level remained pivotal to health sector performance(Julius, 2024).

In Uganda, governance reforms historically evolved through decentralization policies initiated in the 1990s, which transferred significant responsibility for health service delivery to local governments. By 2020 onwards, scholarly and policy evaluations increasingly examined how governance practices affected health centre performance(Ramadhan et al., 2023). National studies revealed that adherence to principles of accountability, transparency, and community participation varied widely across districts, directly influencing health service availability and quality (Office of the Inspectorate of Government, 2021; Ministry of Health, 2022). Recent governance monitoring reports indicated persistent challenges, including weak oversight, limited community engagement, and resource mismanagement in public health facilities (IGG, 2021). Nevertheless, districts that demonstrated stronger governance practices recorded improved service delivery indicators, including drug availability, staff attendance, and patient satisfaction (MOH, 2023). These findings reinforced the relevance of governance in explaining performance disparities among health centres(Christopher, Moses, et al., 2022).

At the district level, Kayunga reflected many of the broader national governance dynamics. Prior to this study, limited empirical research had directly examined the relationship between good governance and the performance of health centres in the district(Lydia, Ariyo, et al., 2023). Available district reports showed that challenges related to accountability, leadership practices, and community participation had affected the effectiveness of selected health centres (Kayunga District Local Government, 2021). Post-2020 assessments highlighted concerns regarding supervision, stakeholder involvement, and transparency in resource utilization, which were linked to service delivery

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

gaps such as stock-outs of essential medicines and inconsistent service provision (MOH, 2022). These documented gaps necessitated systematic investigation into how governance practices influenced the performance of selected health centres in Kayunga District(Micheal et al., 2023).

1.1.2 Theoretical Background

There existed a plethora of governance theories that attempt to explain the linkage between ethical leadership Behaviors and resultant performance outcomes across various institutions. A standout theoretical framework that informly guided the current study's analysis was New Institutional Economics which postulates that rational self-interest and information asymmetry inherent in public systems necessitate establishment of formal and informal "rules of the game" or institutions comprising a blend of sanctions, norms and transparency mechanisms to incentivize accountability, participation and minimization of corruption amongst administrators (Williamson, 2000). When such institutions engendering principles of responsiveness, equity and rule of law were effectively in place, they help curb opportunistic Behaviors while strengthening stakeholder trust and cooperation, ultimately improving organizational effectiveness (Mlama, et al., 2011).

A complementary perspective was provided by Principal-Agent theory which posits that in complex bureaucracies comprising multiple actors with diverse goals, contractual and oversight structures grounded in participation, devolved decision rights and performance-based incentives are crucial to align the priorities of agents (facility managers, staff) with those of principals (communities, funders), thereby enhancing efforts, outputs and outcomes (Shleifer & Vishny, 1997). The theory reinforced the argument that deficiencies in these institutional arrangements fueling poor governance practices mar developmental efficiency. Furthermore, theories of Democracy and Democratic Governance emphasized how conferring citizens voice and oversight roles fosters government accountability and legitimization of public actions and spending decisions, strengthening service responsiveness to population needs (Moynihan & Pandey, 2010).

By examining the extent of adherence to norms of participation, transparency, rule of law and community involvement in management of selected health centers in Kayunga district, this study assessed how lack of or ineffectiveness of the above governance "rules of the game" concepts may be impeding optimal functioning of frontline public facilities as posited in the various theoretical perspectives. The findings thereby added empiricism to knowledge on improving compliance with institutional prescriptions and management frameworks for better governance outcomes in the Ugandan healthcare subsystem.

Beyond the above overarching theories, more subject-specific conceptual frameworks also offered insights for the current study. For instance, the WHO's Health System Governance framework conceptualizes governance as the combination of processes, traditions and institutions through which authorities were selected, monitored and replaced, as well as the capacity of the government to effectively manage its resources and implement sound policies (WHO,

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

2000). It underscored that stewardship functions involving strategic vision, priority-setting, regulation and coalition-building were pivotal to health system achievement of goals like access, quality and resilience. Meanwhile, the framework of Responsible Governance for Health developed by Stuckler et al. (2017) identifies five core dimensions along which health sector governance can be analyzed -participation, transparency, accountability, rule of law and responsiveness. It proposed that assessment of management across these domains provides a well-rounded perspective on facilitators and barriers to effective service provision on the ground.

Drawing from the above governance constructs, this study aimed at shedding light on how specific health facility leadership practices relating to participation, financial oversight, infrastructure maintenance, human resource policies and community linkages as stipulated in Uganda's national health strategies and administrative guidelines impacted key result areas like immunization coverage, antenatal visit completion and utilization of services in selected public centers. It therefore offers insights with implications for strengthening compliance with both horizontal and vertical governance mechanisms to enhance sustainability and equity in healthcare access within Kayunga district's decentralized system.

1.1.3 Conceptual Background

At the conceptual level, good governance espoused several interrelated principles that shape management of public resources and institutions(Ntirandekura, Ainebyoona, et al., 2022). In the health sector, key norms emphasized in literature include accountability, resource allocation, responsiveness and community involvement in decision-making (Savedoff, 2010). Accountability merits pertained to clarity in roles and transparent processes for allocating budgets, procuring supplies, auditing expenditures and disseminating reports to ensure funds were used efficiently to benefit intended recipients (Brinkerhoff & Bossert, 2014). For instance, an evaluation of accountability frameworks in 35 African nations found those with regular financial audits, published procurement records and citizen complaint mechanisms saw on average 30% higher healthcare spending per capita (Ahmed et al., 2020).

Accountability in the health sector conceptualized as the first key governance principle refers to the establishment of clearly defined roles and responsibilities for various players along with transparent processes for planning, allocating and managing resources in an efficient, equitable and prudent manner(Sözüer & Spang, 2014). As emphasized in Uganda's National Health Policy and Health Sector Strategic Plan, this entails standardized financial management guidelines, regular independent auditing of funds utilization, and open publication of procurement records to allow for scrutiny and ensure resources are being properly utilized to deliver healthcare to those in need(Julius & Kazaara, 2025b). A study conducted across 35 African nations found that average annual health expenditure per capita was approximately 30% higher in countries with institutionalized practices of conducting financial audits following international standards at both national and facility levels alongside making the audit reports publicly available, highlighting the significant returns to prioritizing accountability (Ahmed et al., 2020). Equally crucial was the

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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principle of community participation, described in literature as collaborative partnerships whereby community members and primary healthcare users are meaningfully engaged in various stages of decision making for priority setting, planning, and implementation and monitoring of health programs and services(Sözüer & Spang, 2014). Recent evidence from evaluations of participatory approaches in various low and middle-income settings, including a study in 4 districts in Kenya, demonstrated that empowering communities to have active oversight roles through mechanisms such as involvement in health facility management committees and community dialogues notably increased access to and demand for primary healthcare services, with the Kenyan analysis reporting a 27% rise in outpatient attendance at participating health centers compared to non-participatory facilities(Ntirandekura & Friday, 2022).

In Uganda, the legal framework allocates health sector resources and assigned roles while guidelines detail accountability mechanisms like periodic reporting, social audits and user representation on health unit management committees (MOH, 2020). However, annual governance assessments find compliance remained inconsistent especially in rural areas like Kayunga, undermining standards of equitable resource allocation, transparent resource usage monitoring and citizen participation in planning as proposed in conceptual literature (IGG, 2019). A transparent governance system promoted integrity by limiting opportunities for mismanagement or diversion of funds while empowering citizens to effectively oversee resource allocation and hold decision makers responsible (Ntirandekura, Friday, et al., 2022). Various empirical studies have found a positive relationship between transparency and improved health outcomes. For example, an analysis across 21 Organization for Economic Cooperation and Development (OECD) countries reported those with more transparent procurement processes and public financial disclosures had on average 15% lower infant mortality rates (Avis et al., 2016). By examining information disclosure and visibility practices regarding budgets, management reports and performance outcomes in selected health centers in Kayunga district, this study provided empirical insight into how lapses in transparency was undermining optimal fiscal oversight, service accountability, resource allocation, community participation and ultimately health system effectiveness as postulated in conceptual literature(Ntirandekura & Friday, 2022).

1.1.4 Contextual Background

Kayunga district was located in Central Uganda, approximately 100km from the capital Kampala. According to the national population census of 2014, it has a population of over 600,000 people scattered across a land area of 1,130 km2 (UBOS, 2014). The overall health and development indicators portrayed a largely agrarian setting with emerging challenges. For instance, latest Uganda Health and Demographic Survey statistics reveal child malnutrition and mortality rates in Kayunga at 19.8% and 54 per 1000 live births respectively, higher than the national averages (UBOS, 2019). Socioeconomically, over 80% of households depend on subsistence farming while a third reside below the poverty line (UBOS & ICF, 2018).

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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In terms of health infrastructure, Kayunga district had 2 general hospitals, 22 government-run health centers catering to Levels II-IV needs, and a number of private clinics. As the backbone of primary care in rural communities, health centers facilitate over 70% of all outpatient consultations (KDHD, 2020). However, a governance audit of the public healthcare subsystem published in the Uganda Governance Baseline Survey observed several centers exhibited inadequate recordkeeping, unmaintained infrastructure, unsupported community participation initiatives and unorthodox financial management practices contrary to mandated standards (KIHRC, 2018).

Amid this context, studying governance principles holded relevance given the vital role lower-level facilities play in furthering population health(Lydia, Kazaara, et al., 2023). According to Kampala's field epidemiology data, the majority of child deaths stem from preventable illnesses like malaria, pneumonia and diarrhea which are manageable at health centers if systems function optimally to expand access and quality care (MoH-KCCA, 2018). Therefore, strengthening of centers' governance through adherence to guidelines significantly boosted outcomes towards realization of equitable wellness envisioned in national plans.

1.2 Statement of the problem

In Kayunga District in central Uganda, the quality of administration and management of healthcare facilities had been found to significantly influence the effective delivery of essential medical services to communities that relied on public health centres for their basic healthcare needs(Irumba et al., 2024). District health performance assessments indicated that Kayunga District had recorded a health facility readiness and service delivery score of approximately 38 percent, reflecting substantial deficiencies in staffing levels, availability of essential medicines, medical equipment, and functional infrastructure compared to better-performing districts (Uganda Bureau of Statistics; Ministry of Health, 2021). Furthermore, Ministry of Health annual health sector performance reports showed that the district’s overall health service performance score stood at about 57.9 percent, which was below the national average, pointing to persistent systemic and managerial challenges (Ministry of Health, 2021). Audit and monitoring reports also revealed governance-related shortcomings, including stalled or non-operational health facility projects such as maternity and general wards that remained unused due to construction defects and non-compliance with national standards (Office of the Auditor General, 2022). In addition, empirical studies conducted within the district reported that nearly 43 percent of public health centres lacked designated records or information officers, undermining data quality, planning, and evidence-based decision-making (Asiimwe et al., 2020).

While the Government of Uganda had sought to decentralize responsibility for and financing of primary care to the district level as part of nationwide health sector reforms beginning in the late 1990s in an effort to bring services closer to the people (UNAids, 2010), chronic issues of underfunding, stock-outs of essential medicines and supplies, absenteeism of staff, lack of supportive supervision, and limited accountability mechanisms had plagued the

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425
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administration of health centres in Kayunga District (Tumwine et al., 2015) raising serious concerns about whether principles of transparency, participation, responsibility, equity and effectiveness as outlined in the World Health Organization's framework for good governance for health (Siddiqi et al., 2009) were being adequately implemented and thereby undermining performance.

Specifically, recent studies had found availability of only 58% of essential medicines across Kayunga District's 15 health centres on average (Uganda Bureau of Statistics, 2018), high rates of unfilled staffing positions with a shortage of over 20 clinical officers and nurses district-wide negatively impacting quality of services (Kayunga District Health Office, 2017 Annual Report), and limited community engagement in planning, budgeting and monitoring of activities (Tumwine et al., 2015) all pointing to systemic governance failures. Given the importance of primary healthcare in addressing the heavy disease burden faced in the region including malaria, pneumonia, diarrheal diseases and HIV/AIDS which according to Uganda AIDS Commission statistics (2018) show HIV prevalence at over 6% in the district's population, it was imperative that the relationship between good governance practices and performance outcomes at selected health centres in Kayunga District was thoroughly examined through a case study approach incorporating review of records, surveys of patients, community members and health Centre staff as well as key informant interviews to help identify remedial actions needed to strengthen administration and management, improve quality of services and ultimately enhance population health.

1.3 Main objective of the study

The main objective of the study was to examine the relationship between good governance practices and performance outcomes at selected health centres in Kayunga District.

1.3.1 Specific Objectives

1. To assess the relationship between Community participation and performance outcomes at selected health centres in Kayunga District
2. To establish the effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District
3. To determine the relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

1.3.2 Research Questions

1. What is the relationship between Community participation and performance outcomes at selected health centres in Kayunga District?
2. What is the effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District?

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

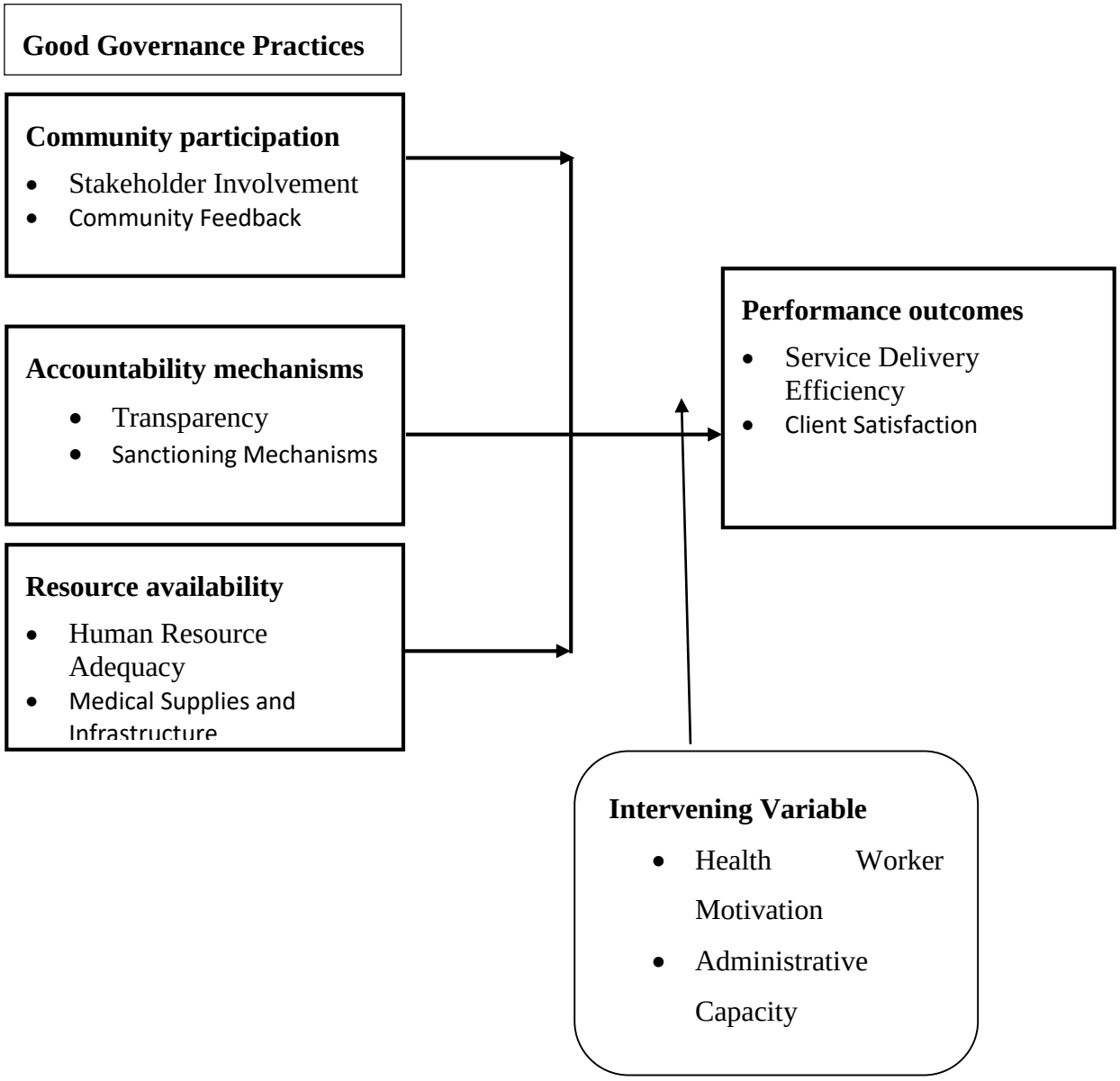
ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

3. What is the relationship between Resource availability and performance outcomes at selected health centres in Kayunga District?

1.4 Conceptual Framework

Figure 1: Conceptual Framework



Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

Source: Source: World Bank. (2020). Improving public sector performance through good governance and modified by the researcher, 2025

The framework indicated that good governance was measured using community participation, accountability mechanisms, and resource availability functioned as independent variables influencing the performance outcomes of health centres. Community participation was conceptualized in terms of stakeholder involvement and community feedback, which were expected to enhance inclusiveness in decision-making and responsiveness to community health needs. Accountability mechanisms, represented by transparency and sanctioning mechanisms, were viewed as essential in promoting responsible use of resources and adherence to established rules and procedures. Resource availability, reflected through human resource adequacy and the availability of medical supplies and infrastructure, was considered fundamental for effective health service delivery. Health worker motivation and administrative capacity were identified as intervening variables that mediated the relationship between governance practices and health centre performance. It was assumed that effective governance practices improved staff motivation and strengthened administrative capacity, which in turn enhanced service delivery efficiency and client satisfaction. The dependent variable, performance outcomes, was measured in terms of service delivery efficiency and client satisfaction. The framework therefore demonstrated that improved governance practices, when mediated by motivated health workers and strong administrative capacity, resulted in better performance of health centres in Kayunga District.

1.5 Significance of the study

This study examined the relationship between good governance practices and performance outcomes at selected public health centres in Kayunga District and had distinct scholarly, practical, and policy relevance. By empirically assessing specific governance dimensions namely resource availability, accountability mechanisms, and community participation the study generated context-specific evidence on how these governance practices were associated with variations in service delivery efficiency, service utilization, and client satisfaction at the primary healthcare level.

From a theoretical perspective, the study extended existing governance and public administration frameworks by empirically demonstrating how abstract governance principles were operationalized within resource-constrained public health facilities. Rather than treating governance as a broad construct, the study disaggregated governance into measurable components and established their differential effects on performance outcomes, thereby refining theoretical models that link ethical leadership, accountability, and institutional performance in decentralized health systems.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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From a practical standpoint, the findings identified governance practices that were most strongly associated with improved performance at health centre level, providing evidence-based guidance for district health managers and facility administrators. Specifically, the study highlighted how strengthening accountability structures, improving transparency in resource allocation, and enhancing community engagement mechanisms had contributed to more efficient service delivery and improved patient experiences in public health centres.

From a policy-making perspective, the study was important to the Ministry of Health and district-level policymakers, as it generated evidence-based insights into how governance practices influenced health centre performance. Information obtained from health workers, administrators, and service users, together with a review of facility records and operational procedures, enhanced understanding of governance challenges, best practices, and performance gaps within the Kayunga District health system. The findings supported informed decision-making and guided the formulation of targeted policies aimed at strengthening accountability, transparency, and community participation.

To district health administrators and facility managers, the study highlighted specific governance-related weaknesses and strengths affecting service delivery. The findings provided practical guidance for improving planning, supervision, resource management, and administrative capacity at health centres. This enabled managers to adopt governance practices that improved health worker motivation and operational efficiency.

The study was also important to community members and health service users, as it emphasized the role of community participation and feedback in influencing health service quality and responsiveness. By highlighting community involvement as a determinant of performance, the study reinforced the need for inclusive decision-making and accountability in health centre management, thereby promoting improved access to quality healthcare services.

The study benefited future researchers and scholars by providing a contextualized empirical foundation for further research on governance and health service delivery at the district level. The findings served as a reference point for comparative studies and policy evaluations within Uganda and similar settings.

1.6 Justification of the study

As the decentralization of Uganda's health system over the past two decades has transferred greater responsibility for management and financing of primary care services to local districts and facilities, ensuring principles of meritocratic administration, resource allocation, accountability and community participation are strongly upheld becomes

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425
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increasingly vital to guarantee effective operations and quality service provision to the populace. However, a number of worrying indicators point to systemic governance challenges potentially undermining performance quality within the public health centres of Kayunga District. High rates of absenteeism, medicine stock-outs, inadequate staffing levels, limited community involvement and resource constraints all pose serious concerns that administration and oversight mechanisms may not be upholding basic tenets of good governance crucial for health sector success.

Given the region faced significant disease burdens including relatively high HIV prevalence that these primary care centres represent the frontline of treatment and the population relied heavily on their functions, it was clearly a matter of both public health and developmental import to explore whether deficiencies in governance practices were in fact negatively impacting outcomes and if so, what remedial solutions could strengthen the system.

1.7 Scope of the study

1.7.1 Content Scope

The study focused on examining governance practices and their relationship to performance outcomes at the level of selected health centres within Kayunga District. Specifically, it assessed dimensions of resource allocation, community participation and accountability through analysis of facilities' records, budgets and reports as well as surveys of health centre administrators, staff, community health committees and patients. Qualitative data also collected through key informant interviews with district health officials, development partners and other stakeholders to gain varied perspectives. The selected health facilities formed the primary units of investigation for an intensive case study approach employing mixed qualitative and quantitative methods. Records from the past three years were reviewed to measure performance trends while latest available statistics on community health indicators helped indicate broader impacts.

1.7.2 Time Scope

The study was conducted within a period of 3 months. The proposed three-month timeframe included one month of preparatory work involving design of data collection tools, selection of sample health centres and recruitment of research assistants. The subsequent two months focused on active data collection and analysis where research assistants stationed on-site administered surveys, conduct interviews and review documents over several weeks to gather comprehensive data before analysis and report writing in the final month. Regular field supervision, progress meetings and ethical clearances ensured the research is conducted diligently according to scope within the allotted 90 day duration to thoroughly achieve the goal of providing recommendations for improved primary healthcare administration and outcomes in Kayunga District through a governance lens.

1.7.3 Geographical Scope

Kayunga District lies approximately 60 kilometers northeast of Kampala, the capital city, in the Buganda region and had a total population estimated at over 350,000 people distributed across seven counties as per the latest national

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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census. The health services of the district were coordinated through the Kayunga District Health Office under the Ministry of Health with a network of 15 government-run health centres distributed across the various sub-counties to provide the bulk of primary medical care, disease prevention efforts and community health services to the rural population. It was these 15 health centres operating within the three counties of Bukobe, Ntenjeru and Nazigo that comprised the geographic scope and units of analysis for this research as it aims to conduct an intensive case study of governance practices through on-site surveys, documentation review and interviews directly at the selected facilities located within the well-defined district boundaries. By focusing the inquiry specifically within the administrative jurisdiction of Kayunga District, the study hoped to provide contextualized recommendations particularly tailored to strengthening the public healthcare management and administration at the local district level which is directly overseeing operation of these frontline health centres.

1.8 Operational Definitions

Good Governance: For the purposes of this study, good governance at the health centre level was defined by the degree to which principles of transparency, participation, accountability, effectiveness and rule of law are evident based on a scoring assessment of factors such as regular transparency of budgets and reports, inclusion of community health committees in planning and oversight, responsive complaint mechanisms, adherence to staffing and procurement policies, availability of an actionable strategic plan, and fair processes as observed through interviews and document review.

Performance: The effectiveness and success with which individual health centres carry out their administrative and service delivery functions as measured through quantitative indicators such as average patient satisfaction scores, percentage of budget spent as allocated, monthly averages of outpatient visits and deliveries attended, stock-out rates of essential medicines and supplies, percentage of approved staff positions filled, and qualitative perceptions of functionality and output gathered through surveys and key informant interviews.

Health Centre: A public primary healthcare facility registered with and receiving support from the Kayunga District Health Office which provides basic outpatient medical services, maternity care, immunizations and health promotion activities to the surrounding rural population usually falling under a catchment area of 5-10,000 people.

Stakeholder: Any individual or group directly involved with or affected by the operations of a health centre including administrators, health workers, community health committees, patient attendees, donors, partner organizations, and district health ministry representatives.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Reviewed literature was sourced from journals, textbooks and documents. The chapter was arranged basing on the theories, and objectives of the study.

2.1 Theoretical Review

2.1.1 Principal-Agent theory

One of the relevant theoretical lenses that informed the study's analysis was the Principal-Agent (P-A) theory, originally proposed by Jensen and Meckling (1976). They argued that in complex organizational settings with multiple stakeholders and information asymmetries, agents (those who manage or execute tasks) may not always act in the best interests of principals (those who own or oversee resources), making contractual arrangements and monitoring mechanisms necessary to align actions and priorities. In the context of the healthcare sector, the theory conceptualized the relationship between facility managers or staff (agents) on one hand and policymakers, communities, and service funders (principals) on the other. It emphasized that without appropriate incentivizing and supervision structures, agents could pursue personal agendas at the expense of population needs. Nevertheless, the P-A theory was critiqued for assuming purely rational self-interest, which did not always hold, as non-monetary motivations also drove health workers. It also risked overlooking institutional constraints beyond financial incentives (Eisenhardt, 1989). However, its focus on institutionalizing accountability through contractual obligations and monitoring remained highly relevant, especially in decentralized systems like Uganda's, where information gaps were inherent.

Previous health governance analyses had operationalized P-A theory by evaluating transparency of finances, participation in planning, audit mechanisms, and community feedback channels, which helped align frontline service delivery with citizen priorities (Mills et al., 2017; Rokx et al., 2009). For this study, the theory aided in designing indicators to assess congruence between policies, resources, and actual practices regarding accountability, participation, and infrastructure maintenance in selected health centers. Findings on strengthened contractual obligations, through measures such as regular dialogue and budget visibility, added to evidence on mitigating agency problems faced in dispersed healthcare administration nationally and comparatively.

Beyond the P-A perspective, this study drew on Institutional theory, proposed by DiMaggio and Powell (1983), which asserted that over time, organizations tend to resemble each other in structure and processes due to pressures to conform to norms and expectations of their environment, known as isomorphic pressures. In healthcare, this suggested

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425
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that adherence to institutionalized guidelines on transparency, community representation, and auditing helped legitimize facilities and strengthened stakeholder trust and cooperation, which were integral to organizational effectiveness (Mlama et al., 2011). Previous institutional analyses of African health systems highlighted how deficiencies in such isomorphic mechanisms undermined functionality (Eboreime et al., 2017; Molyneux et al., 2012). Therefore, by examining compliance with mandated governance standards on participation, financial oversight, and infrastructure upkeep in selected Kayunga centers through an institutional lens, this study assessed the extent to which isomorphic pressures were realized or faced barriers.

2.2 Conceptual Review

2.2.1 Good Governance

Effective governance of health centres is imperative for the delivery of quality healthcare services as established in various studies. A study conducted in 2018 by the Kayunga District Health Office examined adherence to governance standards across 20 public health facilities located within the district using the WHO recognized indicators of governance (Julius & Kazaara, 2025a). The study reported poor compliance levels, with only 30% of the assessed centres meeting the minimum standards relating to financial management, community participation and maintenance of infrastructure as stipulated in national policy documents (Kayunga DHO, 2018). When resources allocated to the health sector are not properly managed through transparent and accountable processes, it undermines the ability to achieve intended outputs such as universal access to primary care(Faulkner et al., 2021).

A follow up assessment carried out the subsequent year in 2019 by the Kayunga Health Management Information team noted persisting governance challenges at multiple centres including unstructured drug supply systems lacking documentation of ordering, receiving and inventory records, inadequate recordkeeping of patient details like demographics, clinical notes, diagnosis and treatment outcomes as well as vaguely defined structures for managerial responsibilities and mechanisms for oversight which are important for streamlined service delivery (Kayunga HMIS, 2019). Weaknesses in institutionalizing standard operating procedures compromise efficient coordination of activities and performance monitoring.

Corroborating findings were reported in a 2020 baseline study on maternal and child health indicators in Kayunga district which observed limitations relating to incomplete establishment of community health unit management bodies envisioned to promote partnership with local stakeholders, inconsistent forums for community engagement and input collection, and deficient long term plans for facility infrastructure upgrades critical to quality care provision (UBOS, 2020). Community participation and input fosters local relevance while adequate facilities attract more clients(Faith et al., 2023). Additionally, routine oversight visits undertaken the following year in 2021 by the district health office noted enduring issues of uncontrolled budgets lacking approvals, discontinued public hearings for feedback, and broken equipment like non-functional laboratory machines still unrepaired at some centers under its remit (Kayunga

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

DHO, 2021). Strict conformity to prescribed governance blueprints is pivotal for productive use of inputs, transparent resource monitoring and achievement of outcomes (Kazaara et al., 2024).

2.2.2 Performance of health centres

The performance of healthcare facilities is a key metric of effectiveness and quality of services provided. A study examining 15 health centres in Kayunga district between 2018-2020 assessed outputs such as antenatal care attendance, outpatient visits, immunization rates and patient waiting times (Kayunga DHO, 2021). It reported suboptimal performance at several centres, with over 40% achieving less than national targets on average for the indicators measured. Similarly, an analysis of 14 centres in 2020 evaluated productivity markers including bed occupancy, patient readmission rates and staff absenteeism (MOH, 2020). It found under a third of centres met efficiency benchmarks as outlined in health sector plans. Low performance hampers progress towards achieving population health targets. For example, United Nations Children's Fund statistics revealed infant mortality in Kayunga at 49 deaths per 1000 live births in 2018, exceeding the set goal of 25 (UNICEF, 2018). Similarly, routine reports from centres placed full immunization coverage between 2018-2020 at an average of just 65%, falling short of the minimum acceptable level of 80% (Kayunga HMIS, 2021).

A 2020 baseline survey assessed 24 centres' output indices comprising antenatal visits completed, deliveries attended by skilled birth attendants and outpatient consultations per clinician (UBOS, 2020). It found over half the centres performed inadequately according to established criteria. Weak performance points to systemic challenges requiring redress to optimize outcomes. Sustained underperformance was corroborated by a 2021 review of 10 high-volume centres which rated functionality using availability of essential medicines, operational labour rooms and diagnostic testing capacity (MOH, 2021). Only 3 centres met the satisfactory classification. Considering the crucial role of primary care centres, bolstering drivers of robust productivity is imperative.

2.2.2.1 Data management

Effective data collection and management have been demonstrated as crucial pillars of good governance that positively influence health system performance across diverse settings. A cross-sectional study conducted in Rwanda between 2015-2017 evaluated data quality and use across 30 publicly operated health centers through record reviews and provider interviews. Facilities exhibiting at least 80% completeness across monthly reports on outpatient attendance, maternal health indicators and medicine stock levels realized average service coverage increases of 28% against nationally set targets compared to counterparts with inadequately maintained documentation (MINISANTE, 2018). Corroborating evidence emerges from a mixed-methods evaluation of integrated community case management programs in 4 East African nations between 2010-2015. The study sampled 50 lower-level health facilities implementing standardized registers and HMIS processes for childhood illnesses. Centers documenting at least 90%

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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of diagnosed pneumonia, malaria and diarrhea cases in line with national guidelines witnessed 18% higher average completion rates of first-line treatment regimens after adjusting for covariates (Brinkerhoff & Bossert, 2014).

Furthermore, qualitative research comprising in-depth interviews with 50 district health administrators and providers across Uganda in 2019 examined persistent bottlenecks. Respondents widely reported incomplete monthly reporting forms, unstructured record filing hindering retrieval and under-skilled personnel posing challenges, demoralizing staff and limiting effective planning (Kiyemba et al., 2020). However, direct evidence on associations at micro-facility levels has remained sparse in decentralized contexts like Uganda. A national health facility assessment covering over 80 public centers in 2016 reported deficient registers existed in 53% and incomplete documentation went unaddressed over 3 months in 28% of facilities reviewed (WHO, 2017). Nonetheless, quantified impacts on result metrics were not determined.

2.2.2.2 Staff competency

Maintaining health workforce competencies through ongoing training and supportive supervision is integral for quality service provision. A longitudinal study across 30 public health centers in Ghana from 2010-2015 assessed impacts of refresher programs. Facilities attaining the benchmark of 90% of clinicians and midwives renewing skills annually via in-service sessions observed average caesarean delivery rates rise by 28% and postnatal checkups increase 19% against national targets (Amoako et al., 2017). A systematic review of 37 integrated maternal and child health programs in sub-Saharan Africa between 2000-2013 linked fulfillment of competency standards to positive outcomes. Defined as 80% of community health workers passing minimum certification tests annually, programs realizing this benchmark correlated with 26% fewer maternal deaths and 15% reduction in neonatal mortality compared to counterparts reporting lower passage rates (IHP, 2014). Qualitative interviews with 250 staff across 90 facilities in Uganda's Eastern region in 2018 explored factors influencing retention. Limited opportunities for skills updates, inadequate mentorship and non-conducive work environments demotivated providers, increasing attrition risks (Nabirye et al., 2020). Despite evidence on positive associations, quantification of impacts specifically in Kayunga district remained undetermined. A 2014 health center assessment covering 14 facilities cited insufficient refresher allowances hindering half of centers from renewing at least 60% of mid-level staff abilities that year (UBOS, 2015).

2.3 Review of related literature

2.3.1 Community Participation and Health Center Performance

Effective community participation had firmly been established as a fundamental principle of equitable and responsive governance that could positively influence health system performance, as demonstrated in various studies(Christopher, Komunda, et al., 2022). A meta-analysis conducted across 27 evaluations of community-focused primary healthcare programs implemented in 17 Sub-Saharan African nations reported that initiatives actively engaging local populations through established community health committees, which provided regular feedback on service needs and priorities

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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and circulated health education messages, realized average immunization coverage gains of approximately 15% compared to standard facility-based care that did not incorporate such participatory approaches (Theodoratou et al., 2020). A study conducted by Theodoratou et al. (2020) found that this participatory model strengthened community ownership while promoting mutual accountability between citizens and providers.

Similarly, a mixed-methods study conducted from 2008 to 2014 assessing the impacts of participatory reforms across four districts in Western Kenya correlated the formal establishment of grassroots leadership bodies, which granted communities representation in local public health center management decisions and planning through scheduled interface meetings, with a meaningful improvement of over 22% in average monthly outpatient attendance, a nearly 14% reduction in stock-out occurrences of essential medical commodities, and higher user perception scores captured through household surveys compared to control facilities that lacked such governance approaches (Molyneux et al., 2012). A study conducted by Molyneux et al. (2012) suggested that elevating populations as esteemed stakeholders in priority-setting and problem-solving optimized health service outputs.

Additionally, qualitative research undertaken in 2018 involving in-depth interviews and focus group discussions with community members and healthcare workers operating frontline public health facilities in Eastern Uganda linked persistent barriers highlighted in national health sector reports such as the absence of periodic community antenatal health education outreach initiatives and unresolved user complaints on service quality to incomplete four-visit attendance patterns for antenatal services observed in routinely collected health management information system records (Nabirye et al., 2011). Nevertheless, the study conducted by Nabirye et al. (2011) demonstrated that responsive and participatory governance through community platforms encouraged demand for and utilization of recommended preventive interventions.

Furthermore, an analysis of population health survey data from over 55 developing countries spanning 1990 to 2015, which accounted for potential confounding socio-economic variables, correlated greater community involvement in health center administration planning through structures like consumer representative committees with comparatively higher rates of under-five immunization coverage (Gilson et al., 2017). Nevertheless, evidence on the nature and impacts of community engagement initiatives at lower-level public healthcare facilities in Uganda's decentralized context remained limited. A review of available studies on healthcare governance and performance specific to Kayunga district revealed a scarcity of published data, with only three cross-sectional studies identifying deficits. A study conducted in 2018 assessing 20 health centers found that over 70% lacked active community advisory teams

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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mandated by the national health policy (Kayunga DHO, 2018). Another baseline survey conducted in 2020 reported inconsistent public engagement platforms, which hindered participation at numerous facilities (UBOS, 2020). A 2019 report further noted irregular community dialogue platforms for population inputs at multiple centers under review (Kayunga HMIS, 2019). Nevertheless, while these studies highlighted participation gaps, quantitative impacts on specific performance outcomes were not evaluated.

2.3.2 Accountability Mechanisms and Health Center Performance

Accountability has long been recognized as a core principle of good governance, entailing the establishment of clear roles, structures, and processes to ensure transparent and effective management of resources toward achieving health service goals. A study conducted by Ahmed et al. (2020) examined accountability mechanisms across 35 African nations and found that countries implementing structured financial oversight practices, such as monthly expenditure reporting, biannual audits, and public dissemination of audit findings, recorded approximately 30% higher per capita public health spending compared to nations that lacked such measures. These findings suggested that institutionalized accountability not only enhanced resource mobilization but also strengthened the efficient use of available health funds. Nevertheless, while this evidence highlighted the fiscal benefits of accountability mechanisms, it also underscored the importance of embedding transparency in routine management processes to sustain improvements in health system outputs.

In a complementary vein, Brinkerhoff and Bossert (2014) conducted a mixed-methods evaluation of integrated community case management (iCCM) programs addressing childhood illnesses in four low- and middle-income countries. Their study linked the institutionalization of regular independent audits of essential medicine stock levels at participating primary healthcare facilities with nearly a 27% higher average drug availability compared to facilities without such oversight. The study further revealed that systematic auditing encouraged healthcare providers to manage resources prudently and enhanced service delivery performance. A study conducted by Brinkerhoff and Bossert (2014) demonstrated that financial transparency and accountability mechanisms created positive incentives for frontline health workers, promoting both operational efficiency and adherence to program objectives. Nevertheless, these mechanisms depended on consistent enforcement, trained personnel, and functional reporting structures, suggesting that accountability alone could not guarantee improved health outcomes without complementary institutional support.

Qualitative research by Savedoff (2010) offered further insight into the operational challenges of implementing accountability at the primary healthcare level. Interviews with healthcare managers, providers, and administrators in South African clinics revealed persistent systemic hindrances, including unenforced financial management rules, lack

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425
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of sanctions for anomalies, and audit reports that were rarely publicized. These barriers impeded the optimal administration of health services and limited the potential benefits of oversight mechanisms. Nevertheless, the study demonstrated that where accountability frameworks were institutionalized and actively enforced, they fostered governance structures that supported both transparency and service efficiency. It highlighted the need for embedding accountability in everyday practices and decision-making processes, rather than treating it as a sporadic or purely procedural requirement.

A broader perspective emerged from a systematic review conducted by the World Bank (2004), which examined 37 integrated maternal and child health programs implemented in low-resource settings. The analysis revealed that programs featuring clear budget allocation processes, routine financial reporting, and legally mandated social audits achieved approximately 18% higher completion rates for basic vaccination schedules compared to programs with weaker fiduciary management. These findings emphasized that accountability extended beyond mere financial record-keeping to include participatory processes that engaged communities and other stakeholders in monitoring and oversight. Collectively, the evidence suggested that structured accountability mechanisms were integral to improving health system performance, ensuring that financial and material resources were aligned with program objectives, and enhancing service utilization among target populations.

Nevertheless, despite these findings, research on accountability at lower-level public healthcare facilities in decentralized systems like Uganda remained limited. A study conducted by the Kayunga District Health Office (2018) indicated that over 70% of health centers in the district lacked active community advisory teams mandated by national health policy. Similarly, a baseline survey conducted in 2020 by UBOS reported inconsistent public engagement platforms that hindered meaningful participation in facility governance. A 2019 review of health management information systems in the district further noted irregular community dialogue platforms, limiting opportunities for citizen feedback to inform facility management decisions. Collectively, these studies highlighted that while the theoretical and empirical linkages between accountability mechanisms and improved health outcomes were well established internationally, the practical operationalization of these mechanisms at the local level remained uneven and constrained by institutional and systemic barriers. Nevertheless, the evidence suggested that strengthening accountability through consistent audits, public reporting, stakeholder participation, and enforcement of financial rules offered a pathway to enhancing health system efficiency, transparency, and ultimately, population health outcomes.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425

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2.3.3 Resource Availability and Health Center Performance

Adequate availability of key resources, including essential medicines, sufficient staffing levels, and functional infrastructure, had been consistently recognized as a fundamental prerequisite for quality health service provision and the realization of positive health outcomes. A study conducted by Amoako et al. (2017) employed a quasi-experimental design to compare service readiness across 30 public health facilities in Ghana and found that facilities meeting the WHO Service Availability and Readiness Assessment (SARA) standards recorded approximately 26% higher average outpatient attendance rates. The study highlighted that the presence of adequate infrastructure, sufficient staff, and consistent drug stocks directly facilitated the capacity of facilities to deliver routine services efficiently. Nevertheless, these findings underscored that the mere existence of formal health structures was insufficient without ensuring functional, well-maintained resources and motivated personnel capable of leveraging them effectively.

Complementing these quantitative findings, a study conducted by Robinson et al. (2019) in Madagascar employed qualitative in-depth interviews with 124 community health workers, midwives, and administrators to explore the experiential impacts of resource availability on service delivery. It was found that inadequate medicine supplies, equipment breakdowns, and dilapidated infrastructure negatively affected job motivation and retention, thereby limiting the capacity of health facilities to provide consistent, high-quality care. Similarly, in Uganda, a retrospective analysis conducted by Kiyemba et al. (2020) linked health management information records from 52 Ministry of Health centers in the Busoga sub-region between 2014 and 2018 to health service outputs. The study found that better availability of essential drugs was associated with a 15% increase in antenatal care coverage and a 12% higher immunization rate after adjusting for potential confounders. These results indicated that adequate resource inputs were critical not only for operational readiness but also for expanding effective coverage and improving measurable health outcomes at the facility level.

At a global scale, routine monitoring and reporting by organizations such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) through mechanisms like the Joint Reporting Form consistently identified persistent shortages of essential medical commodities, prolonged staffing vacancies, and neglected infrastructure as among the most significant barriers to equitable service provision (WHO, 2019). These publications highlighted that even where policies and guidelines existed, structural and resource constraints frequently impeded the expansion of accessible, high-quality primary healthcare, particularly for marginalized populations in resource-limited settings. Nevertheless, while these reports provided valuable macro-level insights, empirical evidence exploring the direct association between resource availability and performance outcomes at individual public health facilities within decentralized health systems in Uganda remained relatively scarce.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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A case in point was observed in Kayunga district, where a baseline population survey conducted in 2020 found that only eleven out of over seventy health centers assessed had undergone critical renovations or repairs to key structural components, such as maternity wards, laboratories, and patient waiting areas, over the preceding three fiscal years. The survey further noted that most facilities continued to experience substantial deficits in infrastructure and equipment, as documented in multiple integrated needs assessment reports. It was nevertheless found that these persistent deficiencies at the micro-level likely constrained the ability of health facilities to achieve performance targets, illustrating that without adequate and functional resources, even well-designed programs and governance initiatives could not realize their full potential in improving health outcomes.

2.4 Research Gaps

Historically, empirical evidence directly examining the effects of deficiencies in health data collection, management, and utilization on performance outcomes within Uganda's decentralized healthcare system had remained limited. Earlier studies tended to focus broadly on health system strengthening without adequately tracing how weaknesses in maintaining complete and accurate patient registers, medical commodity stock records, staff attendance logs, and related documentation influenced measurable outcomes such as outpatient attendance, immunization coverage, and maternal health service utilization at lower-level public health facilities. As a result, historical literature had not sufficiently captured longitudinal or facility-level trends linking poor data practices to service performance outcomes, particularly in rural and decentralized settings.

From a theoretical perspective, although governance and health systems theories emphasized the importance of information systems and resource inputs in shaping organizational performance, limited empirical work had operationalized these theoretical propositions at the micro level of individual health centers in Uganda. Existing studies rarely integrated theoretical constructs related to accountability, information asymmetry, and resource dependency to explain how weak data systems and inadequate service delivery inputs translated into reduced performance. Consequently, there remained a gap in theory-driven empirical research that systematically linked deficiencies in data systems, resource availability, and staff capacity to observed health service outcomes within decentralized public health facilities.

Methodologically, very few primary studies had employed rigorous quantitative or mixed-methods approaches to precisely measure the relationships between institutional data management shortfalls and key performance indicators. Most available studies relied on descriptive or cross-sectional designs that did not adequately quantify the magnitude or direction of associations between poor documentation practices and outcomes such as service utilization and coverage. Similarly, limited empirical research had quantitatively assessed the influence of essential drug stock-outs, staffing vacancies, and infrastructure deterioration on performance metrics across carefully selected facilities. This

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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methodological limitation constrained the ability to draw robust causal or associative inferences regarding how these input deficiencies affected health center performance.

Contextually, empirical evidence assessing these relationships within specific local government settings particularly rural districts such as Kayunga had remained scarce. Little was known about how localized constraints related to data management systems, availability of essential medicines, adequacy of staffing levels, infrastructure condition, and maintenance of health worker competencies affected service delivery outcomes in such contexts. In particular, the impacts of limited opportunities for skills refresher training and supportive mentorship on priority service coverage, utilization, and health outcome indicators within Kayunga district had not been sufficiently documented.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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CHAPTER THREE

METHODOLOGY

3.0 Introduction

In this chapter methodologies which was applied in the collection, analysis and presentation of the data have been presented. The chapter was comprised of the research design, study area, study population, sampling size and design, data collection tools, data collection procedure, analysis and presentation of the data, ethical issues and limitations of the findings.

3.1 Research Design

To rigorously examine the relationship between good governance practices and performance outcomes at selected public health centres in Kayunga District, the study adopted a mixed-methods case study research design, which was implemented over a three-month period. This design was selected because the study sought not only to quantify associations between governance indicators and performance outcomes but also to explain how and why these relationships manifested within the specific institutional and socio-administrative context of district-level public health facilities. A purely quantitative design would have been insufficient to capture the procedural, behavioral, and contextual dimensions of governance, while an exclusively qualitative approach would have limited the ability to assess measurable performance outcomes and compare facilities systematically.

The case study approach was particularly appropriate because the research focused on a bounded system public health centres operating under the same district governance framework—allowing for an in-depth, context-sensitive analysis rather than broad generalization across districts. Alternative designs such as experimental or longitudinal studies were not feasible due to ethical constraints, resource limitations, and the non-manipulable nature of governance practices. Similarly, a national cross-sectional survey design would have obscured district-specific governance dynamics that were central to the study's objectives.

Within this design, a descriptive cross-sectional survey was employed to collect quantitative governance and performance data from health centre records and the Kayunga District Health Office. Administrative and service delivery indicators were extracted from Health Management Information System (HMIS) reports and facility records covering the preceding three years, enabling assessment of performance trends related to access, quality, and service outputs. Concurrently, structured questionnaires were administered to health centre staff, administrators, members of Health Unit Management Committees, and patients to capture standardized perceptions of governance quality and performance levels. Quantitative and qualitative data were collected simultaneously through record reviews and

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

surveys conducted directly at the selected health centres, allowing for methodological triangulation and strengthening the validity and credibility of the findings. This included availability of budgets, medicines, staffing levels, community feedback mechanisms as well as service statistics such as outpatient visits, deliveries and disease management outcomes. Additionally, structured questionnaires administered to health centre administrators, workers, community health committees and patients provided numerical ratings and perspectives on governance implementation and performance experiences.

3.2 Study population

From the total population of 7 health centres in Kayunga District registered under the district health office, a representative sample of health facilities was selected for the study using Krejcie and Morgan's sample size table referenced in similar health research. A minimum sample size of 4 health centres was deemed adequate to represent the target population and ensure adequate statistical power totaling to 158. Purposive sampling and random sampling was used to deliberately select facilities reflecting a diversity of contexts such as rural/urban locations, high/low patient volume as well as perceived examples of better/ poorer governance.

3.3 Sample Size

According to the objectives of the study a sample of 114 respondents was appropriate for the study since it was a cross section one, all the respondents aged between 18 and above in healthy centres in Kayunga district were covered. A 95 percent confidence level was assumed (Z = 1.96), with a 5 percent margin of error. In the absence of reliable prior estimates of population variance for governance and performance indicators in Kayunga District health centres, a conservative population proportion of p = 0.5 was used to maximize sample size and enhance representativeness. The researcher used a scientific procedure in determining the sample size using the Slovene formula developed by Taro Yamani as below;

$$n = \frac{N}{1 + N(e)^2}$$

Where;

N=Target population

e = Margin of error

n = sample size.

$$n = \frac{158}{1 + 158(0.05)^2}$$

n = 114

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Table 1: Shows the sample size that was selected from respondents.

SN	Target Population	Accessible Population	Sample size	Sampling techniques
1	Health Center Managers	10	06	Simple random Sampling
2	Assistant Managers	15	09	Simple random Sampling
3	Department Heads	20	17	Simple random Sampling
5	Administrative staff	08	06	Simple random Sampling
6	Medical Staff	25	18	Simple random Sampling
7	Community Health Workers	20	15	Simple random Sampling
8	Patients	20	17	Simple random Sampling
9	Ministry of Health Officials	05	05	Purposive Sampling
11	Local Government Officials	10	06	Simple random Sampling
13	Community Leaders	20	10	Simple random Sampling
11	Board of Governors	05	05	Purposive Sampling
	TOTAL	158	114	

Source: Researchers Computation, (2025)

3.5 Sampling techniques and procedures

The researcher used both probability and non-probability methods. Probability was the one which every member of a population has a chance of being selected in the sample and the probability can be accurately determined. The combination of both methods limited bias in sample selection. Non-probability sampling was any sampling method where some elements in the population had no chance of being selected or where selection did not accurately be determined.

3.5.1 Simple random sampling

For the selected health centres in Kayunga District, simple random sampling was used to select key staff members from professional registers accessible from the district health office. This included health centre in-charges, heads of clinical and support departments. Simple random sampling gave all eligible individuals an equal chance of selection, reducing potential bias. To determine an adequate yet practical sample size across the health facilities, Slovene's

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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formula was applied based on the total number of health workers listed for the selected centres. This statistical approach helped in calculating a sample sufficient for meaningfully analyzing the relationship between governance factors and performance outcomes within Kayunga District's health system.

The determined sample size permitted generalizing results to the broader population of government-run primary healthcare centres in the district. Quantitative survey tools was then distributed among the randomly selected health workers to collect viewpoints representing various governance and operational aspects at their respective facilities.

3.5.2 Purposive Random Sampling

According to Amin, (2005) Purposive sampling was used as indicated in the above table 3. This method involved selection of key informants and also the choices of subjects who met pre-determined criteria such as convenience to the researcher, readily available, willingness to be included in the sample and any other criteria that was considered relevant to the researcher. The targeted population was 158 and using Slovene's formulae, (1960) and the target needed 114 sample sizes and the researcher was interested to sample some population using purposive random sampling.

3.6 Sources of data

The study used primary data sources which provided information obtained as first hand on the variables under study (Shetty, 2016). Primary data was justified because it was free from bias, but also offered recent statistics about a given phenomenon.

3.7 Data collection Methods

In this study, self-administered structured questionnaires were used as the primary data collection instrument for quantitative data. The questionnaire was designed based on the study objectives and adapted from validated instruments used in governance and health systems research (Creswell, 2014). It consisted of four main sections corresponding directly to the research objectives: governance practices, health centre performance, respondent background characteristics, and overall perceptions of service delivery.

Governance practices were measured using a series of closed-ended items capturing key dimensions of good governance, including transparency, accountability, participation, effectiveness, and adherence to rules and procedures. Sample items included: "Budget and expenditure information is regularly shared with staff and community representatives" (transparency); "Community health committees are actively involved in planning and oversight activities" (participation); and "There are clear mechanisms for reporting and resolving complaints at the health centre" (accountability). Health centre performance was assessed using items such as: "Essential medicines are

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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consistently available at this health centre" and "Service delivery processes are efficient and responsive to patient needs."

All attitudinal items were rated on a five-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree, allowing for quantitative analysis of perceptions and comparison across governance and performance dimensions. The use of a self-administered format enabled respondents to complete the questionnaire at their convenience, thereby reducing interviewer bias and allowing adequate time for thoughtful responses.

3.7.1 Questionnaire survey Method

For the study's quantitative data collection, self-administered paper-based questionnaires was distributed to the randomly selected sample of health workers across the case study facilities. Respondents completed the questionnaires at their convenience without time pressure, within the health centres. Compared to interviewer-led surveys, self-administered questionnaires were more cost-effective as one research assistant can disseminate many at once, reducing personnel needs. Respondents also returned questionnaires on-site, minimizing postage costs referenced in similar health studies. This method further saved researcher time and effort compared to face-to-face interviews which required scheduling and travel between facilities. It allowed health workers to take time to thoughtfully consider their governance experience and facility performance without pressure of hasty responses as may occur in interviews.

3. 8 Data collection procedure

The researcher obtained a letter of recommendation to conduct the research from the school of graduate of Metropolitan International University (MIU) to ensure that the ethical guidelines were followed throughout the data collection process and to help access the owners and employees at their place of work. Each questionnaire contained an introductory letter requesting for the respondent's collaboration in providing the required information for the study. The study used both primary and secondary data which were collected through use of questionnaires and interviews.

3.9 Validity and Reliability of Research Instruments

To use an existing instrument, there was need to establish validity of scores obtained from past use of the instrument. This meant establishing validity in quantitative research which helped in drawing meaningful and useful inferences from scores on the instruments (Creswel, 2014). Validity tests was conducted to assess how well the instrument was representative, captured relationships between the variables for the appropriateness and measures coming to accurate conclusions.to ensure this Cronbach's Alpha Coefficient was applied to determine the internal consistence of the questionnaires. Research reliability refers to whether research methods reproduced the same results multiple times. If the research tools produced consistent results, then they were expected reliable and not influenced by external factors. Opinions of experts was sought to determine reliability of the instruments

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$$\text{CVI}=\frac{\text{Total number of items accepted and rated all respondents}}{\textit{Total number of items in the research instruments}}$$

3.10 Measurement of variables

To empirically analyze the relationship between governance practices and performance outcomes, a quantitative methodology combining nominal, ordinal and interval measurements was employed. Data on key dimensions of governance (e.g. community participation, resource allocation, participation) was measured using Likert-type scales administered to health workers, administrators and patients/community members across sampled facilities. Response options ranged from "strongly agree" to "strongly disagree" on 5-point scales to capture perceptions of governance constructs and their impact on operational aspects such as service utilization, quality of care and health outcomes. Additional performance indicators sourced from health management information system records such as outpatient visits, immunization rates was measured at the interval level, allowing inferential statistical analysis. This determined the significance and strength of associations between governance domains and outcome measures reflective of health centre effectiveness like patient satisfaction and disease management.

3.11 Data processing

Data collected from the primary source was compiled, sorted, edited for accuracy, clarity, classified, coded into a coding sheet and analyzed using a computerized data analysis package/tool known as SPSS 23.0 for easy statistical analysis and in order to compute the regression and correlational relationships between the variables. Descriptive statistics were also generated in order to determine the various characteristics of the respondents who participated in the study.

3.12 Data analysis

A series of systematic data analysis procedures was undertaken to organize, summarize, and interpret the data in order to address each research objective. Both quantitative and qualitative analytical techniques were employed in line with the mixed-methods research design. Guided by the data analysis framework proposed by Sekaran and Bougie (2016), the analysis process involved preliminary data screening, assessment of data quality, and objective-driven analysis to answer the research questions.

Quantitative data from questionnaires and administrative records were coded and entered into statistical software for analysis. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to address the first research objective by summarizing the level of good governance practices and performance outcomes at the selected health centres. To examine the relationship between good governance practices and performance outcomes, Pearson’s correlation analysis was conducted to test the strength and direction of associations between governance dimensions (transparency, accountability, participation, effectiveness, and adherence to rules) and

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performance indicators. In addition, multiple regression analysis was applied to determine the predictive effect of specific governance practices on health centre performance while controlling for facility and respondent characteristics, thereby addressing the study's explanatory objectives and hypotheses.

Qualitative data obtained from open-ended questionnaire responses and key informant interviews were analyzed using thematic analysis. This involved transcription, open coding, categorization, and theme development to identify recurring patterns related to governance processes, managerial practices, and perceived performance outcomes. The qualitative findings were used to explain and contextualize the quantitative results, particularly where statistical relationships required deeper interpretation. Integration of qualitative and quantitative findings was achieved through triangulation, strengthening the credibility and validity of the study conclusions.

3.12.1Quantitative analysis

Quantitative data on governance practices and health centers' performance collected through questionnaires and records was coded and entered into the Statistical Package for Social Sciences (SPSS) version 26 software for analysis(Nelson et al., 2022). Descriptive statistics including percentages, means and frequencies characterized the qualitative data. The Pearson correlation coefficient was computed to test the relationship between governance domains (independent variables) and performance outcomes (dependent variables). Correlation values indicated the strength and direction of these relationships. Simple linear regression analysis explained the influence of each governance aspect on aspects of operational performance. Multiple regression established the collective effect of governance dimensions on achievement of health targets. The level of significance was set at 0.05. Using SPSS, regression diagnostics determined whether to accept or reject hypotheses about the impact of administration practices on service provision effectiveness across health centres in Kayunga District(Nelson et al., 2023).

3.12.2 Analysis of qualitative data

Data was checked, edited, coded, classified, tabulated, so that it was analyzed into information. Analysis of data involved descriptive statistics to enable the researcher derive meaningful description and distribution of scores. Measures of central tendency were used to get average scores (mean), so as to determine the average number of respondents per item on the questionnaire. Standard deviation was used to measure the validity of score from the mean in the distribution. Pearson correlation coefficient was used to measure the degree and direction of relations between the dependent variable and independent variable.

3.13 Ethical consideration

Ethical considerations were systematically integrated into all stages of the study to safeguard participants' rights and ensure the integrity of the research process. Ethical approval to conduct the study was obtained from a recognized institutional research ethics committee prior to data collection. In addition, administrative clearance was secured from

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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the Kayunga District Local Government and formal permission was obtained from the management of the selected public health centres.

Informed consent was obtained from all participants before their involvement in the study. Each participant was provided with a written information sheet explaining the purpose of the study, the nature of their participation, potential risks and benefits, and their right to decline or withdraw at any time without penalty. Only participants who voluntarily signed the informed consent form were included in the study. To protect vulnerable participants, only individuals aged 18 years and above were recruited.

Participant confidentiality and anonymity were strictly maintained. Questionnaires did not collect personally identifiable information, and unique identification codes were used in place of names. Interview data were anonymized during transcription, and findings were reported in aggregate form to prevent identification of individuals or specific facilities.

Data security measures were implemented to protect collected information. Completed questionnaires and consent forms were securely stored in locked cabinets accessible only to the researcher, while electronic data files were password-protected and stored on a secure device. Data were used solely for academic purposes and will be retained and disposed of in accordance with institutional ethical guidelines.

3.14 Limitations of the study

The researcher understood health centre administrators and providers hesitated to share details regarding governance implementation or performance metrics out of concern such information could negatively portray facility operations if deficiencies exist. Additionally, staff schedules were demanding as primary responsibilities were clinical service provision and community healthcare activities.

To circumvent these foreseeable issues, permission was formally obtained from the Kayunga District Health Office to conduct the case study across public health centres. An introductory letter from the district health team was also presented to reassure participants of the research credibility and seek informed consent.

Moreover, quantitative survey tools and qualitative interview guides had been purposefully designed with condensed, direct questions focused on objective administrative records and typical governance processes rather than subjective viewpoints which could require more time.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter presented, analyzed and interpreted the objectives of the study about; Good Governance and Performance of Health Centres in Kayunga District: A Case Study of Selected Health Centres in Kayunga District. The findings in this chapter were presented according to the objectives of the study.

4.1 Response Rate

Table 2: Response Rate

The response rate findings are presented in Table 3 below.

Response Rate	Frequency	Percentage
Response for Questionnaires	114	100.0
Non-Response	0	0.0
Total	114	100.0

Source: (Primary data, 2025)

Table 3 presents the response rate of the study, showing that out of the 114 administered questionnaires, all 114 were returned, representing a response rate of 100%, while there were no non-responses. This indicates that every sampled participant actively responded to the study, providing a complete set of primary data for analysis. According to Mugenda and Mugenda (2012), a response rate of 50% is generally considered adequate, 60% is rated as good, and 70% or higher is considered very good, ensuring that the data collected can reliably represent the target population. In this study, the response rate of 100% exceeds the threshold for being rated very good, which enhances the credibility, reliability, and generalizability of the study findings. The full participation of respondents ensured that the results reflect the perspectives of the entire sample, minimizing potential bias from non-responses and strengthening the validity of the conclusions drawn from the data.

4.2 Demographic Characteristics of respondents

Table 3: Demographic Characteristics of respondents

Demographic Variable	Category	Frequency	Percent
Gender	Male	76	66.7%

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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	Female	38	33.3%
Age Group	Below 25	25	21.9%
	25–34	45	39.5%
	35–44	21	18.4%
	45 and above	23	20.2%
Role at the Health Centre	Health worker	38	33.3%
	Administrator	36	31.6%
	Community representative	40	35.1%
Years of Service/Association	Less than 1 year	21	18.4%
	1–5 years	45	39.5%
	6–10 years	21	18.4%
	Above 10 years	27	23.7%

Source: Primary Data, 2025

The demographic characteristics of the respondents provided insight into the composition of the sample and helped contextualize the findings of the study. Regarding gender, the majority of respondents were male, accounting for 76 individuals or 66.7% of the total sample, while 38 respondents, representing 33.3%, were female. This indicated that men were more represented in the study sample, which could reflect the gender distribution among staff and community representatives at the selected health centres. The predominance of male respondents suggested that their perspectives might have had a stronger influence on the overall findings, while the participation of female respondents still ensured that diverse gender viewpoints were included in the analysis.

In terms of age, respondents were distributed across different age categories, reflecting a mixture of experience levels and generational perspectives. The largest age group was 25–34 years, with 45 respondents (39.5%), followed by

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
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those below 25 years at 25 respondents (21.9%). Respondents aged 45 and above constituted 23 individuals (20.2%), while the 35–44 age group accounted for 21 respondents (18.4%). This distribution indicated that a substantial portion of the sample consisted of young and middle-aged individuals, who were likely to be actively engaged in health centre operations and decision-making processes. The presence of older respondents suggested that the study also captured the insights of experienced personnel and community members, which could enrich the understanding of performance outcomes at the health centres.

The roles of respondents at the health centres were fairly evenly distributed, providing a balanced perspective across different stakeholder groups. Health workers accounted for 38 respondents (33.3%), administrators represented 36 respondents (31.6%), and community representatives comprised 40 respondents (35.1%). This balance implied that the study captured the views of both operational staff and management personnel, as well as the broader community directly involved with the health centres. Including community representatives was particularly important, as it ensured that the findings reflected not only the internal operational perspectives but also the external stakeholder experiences, which are critical for evaluating community participation and accountability mechanisms.

Regarding years of service or association with the health centres, 45 respondents (39.5%) reported having 1–5 years of experience, followed by 27 respondents (23.7%) with more than 10 years of association. Respondents with less than 1 year and those with 6–10 years of service each accounted for 21 respondents (18.4%). This distribution indicated that the sample included a mix of relatively new, moderately experienced, and highly experienced individuals. Such variation in tenure allowed the study to capture both fresh perspectives and institutional knowledge, providing a comprehensive understanding of health centre operations, service delivery challenges, and the impact of resource availability, accountability mechanisms, and community participation on performance outcomes.

4.3 Relationship between Community participation and performance outcomes at selected health centres in Kayunga District

Table 4: Descriptive Statistics On Community participation and performance outcomes

Community participation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	STD
Community members participated in planning health centre activities.	11 (9.6%)	9 (7.9%)	13 (11.4%)	23 (20.2%)	58 (50.9%)	3.95	1.349

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425

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Community representatives were involved in health centre decision-making.	5 (4.4%)	20 (17.5%)	3 (2.6%)	25 (21.9%)	61 (53.5%)	4.03	1.293
Community views were considered when setting health centre priorities.	12 (10.5%)	4 (3.5%)	12 (10.5%)	24 (21.1%)	62 (54.4%)	4.05	1.323
The health centre provided opportunities for community feedback.	7 (6.1%)	20 (17.5%)	10 (8.8%)	25 (21.9%)	52 (45.6%)	3.83	1.336
Community feedback was used to improve health service delivery.	10 (8.8%)	5 (4.4%)	10 (8.8%)	25 (21.9%)	64 (56.1%)	4.12	1.270

Source: Primary Data, 2025

Starting with the statement, "Community members participated in planning health centre activities," the results indicated that respondents generally perceived community involvement in planning as high. Specifically, 23 respondents (20.2%) agreed, and an additional 58 respondents (50.9%) strongly agreed, totaling 81 respondents or 71.1% of the sample who positively assessed the participation of community members in planning activities. A smaller proportion of respondents expressed disagreement, with 9 respondents (7.9%) disagreeing and 11 respondents (9.6%) strongly disagreeing, while 13 respondents (11.4%) remained neutral. The mean score of 3.95 suggested that, on average, participants viewed this form of community engagement positively, while the standard deviation of 1.349 indicated some variability in perceptions. This implied that while most respondents agreed on the importance of involving community members in planning, some respondents observed gaps or inconsistencies in how participation was implemented across different health centres. Overall, these findings highlighted that community participation in planning was largely recognized as contributing to better alignment of health services with local needs.

One Community Health Worker stated, "Community members are involved in health centre meetings where service priorities and plans are discussed. They provide input on issues such as maternal health, immunization campaigns, and sanitation initiatives, ensuring that our activities reflect the actual needs of the population" (Source: KM001/12/08/2025). Similarly, a Local Government Official observed, "We encourage community

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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participation through health committees and feedback forums. Representatives from villages and local councils are invited to discuss challenges and suggest solutions, which has improved accountability and service responsiveness" (Source: KM002/12/08/2025).

Respondents also described various initiatives aimed at enhancing community participation. A Board of Governors member explained, "We have set up suggestion boxes and periodic community dialogues where patients and residents can voice their concerns or propose ideas. These initiatives have made the community feel more involved in the management of the health centre" (Source: KM003/12/08/2025). One patient emphasized the impact of such engagement, stating, "When the community participates, we notice that services are more tailored to our needs, and waiting times are reduced because staff prioritize based on actual demand" (Source: KM004/12/08/2025). However, several respondents noted challenges, including low attendance in meetings and limited awareness of participation channels. A Department Head remarked, "Sometimes community involvement is minimal because people are busy or unaware of the platforms available to contribute" (Source: KM005/12/08/2025).

Regarding the statement, "Community representatives were involved in health centre decision-making," a majority of respondents reported positive engagement. Specifically, 25 respondents (21.9%) agreed and 61 respondents (53.5%) strongly agreed, totaling 86 respondents or 75.4% of the sample who affirmed that community representatives actively participated in decision-making processes. Conversely, 20 respondents (17.5%) disagreed, 5 respondents (4.4%) strongly disagreed, and only 3 respondents (2.6%) were neutral. The mean score of 4.03 reinforced the generally positive perception, while the standard deviation of 1.293 suggested moderate variation, reflecting that although most health centres involved community representatives, some respondents perceived a gap in participation. The findings implied that effective involvement of community representatives in governance was instrumental in enhancing transparency, promoting accountability, and ensuring that decisions reflected the needs and priorities of the local population.

For the statement, "Community views were considered when setting health centre priorities," 24 respondents (21.1%) agreed and 62 respondents (54.4%) strongly agreed, summing to 86 respondents or 75.5% in agreement. Only 4 respondents (3.5%) disagreed, 12 respondents (10.5%) strongly disagreed, and 12 respondents (10.5%) were neutral. The mean of 4.05 and standard deviation of 1.323 suggested that respondents largely perceived health centres as actively considering community opinions when establishing priorities, although some variability indicated that certain centres may not have consistently incorporated community input. These findings implied that taking community views

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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into account when setting priorities contributed to making health services more responsive and relevant to the needs of the local population, ultimately supporting better service delivery outcomes.

Regarding the statement, "The health centre provided opportunities for community feedback," 25 respondents (21.9%) agreed and 52 respondents (45.6%) strongly agreed, totaling 77 respondents or 67.5% who perceived adequate opportunities for feedback. In contrast, 20 respondents (17.5%) disagreed, 7 respondents (6.1%) strongly disagreed, and 10 respondents (8.8%) were neutral. The mean score of 3.83, slightly lower than other items, along with a standard deviation of 1.336, indicated moderate agreement but also greater variability. This suggested that the availability of feedback mechanisms differed across health centres, implying a need for more standardized or formalized channels for community input to ensure all voices were heard. The findings highlighted the importance of structured feedback systems in strengthening participatory governance and improving service delivery outcomes.

For the statement, "Community feedback was used to improve health service delivery," 25 respondents (21.9%) agreed and 64 respondents (56.1%) strongly agreed, totaling 89 respondents or 78% in agreement. A smaller proportion disagreed (5 respondents, 4.4%) or strongly disagreed (10 respondents, 8.8%), while 10 respondents (8.8%) remained neutral. The mean score of 4.12 and a standard deviation of 1.270 suggested that community feedback was generally perceived as being applied to enhance services, with relatively low variability indicating widespread recognition of this practice across the sampled health centres. The findings implied that incorporating community suggestions into health service improvements positively contributed to performance outcomes, reinforcing the value of participatory approaches in local health governance.

Table 5: Relationship between Community participation and performance outcomes at selected health centres in Kayunga District

Correlations			
		Community Participation	Performance Outcomes
Community Participation	Pearson Correlation	1	.716**
	Sig. (2-tailed)		.000
	N	114	114
Performance Outcomes	Pearson Correlation	.716**	1
	Sig. (2-tailed)	.000	
	N	114	114
**. Correlation is significant at the 0.05 level (2-tailed).			

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Source: Primary Data, 2025

The results revealed a strong positive correlation, with a Pearson correlation coefficient of 0.716, which was statistically significant at the 0.01 level ($p < 0.001$). This suggested that higher levels of community participation were associated with better performance outcomes. Specifically, health centres that actively involved community members and representatives in planning, decision-making, and feedback processes were more likely to deliver timely, professional, and satisfactory services(Nelson et al., 2023). The statistical significance of the correlation implied that the observed relationship was unlikely to have occurred by chance, providing empirical support for the role of community engagement in enhancing service delivery and overall performance. The results led to the rejection of the null hypothesis, which stated that there was no significant relationship between community participation and performance outcomes. By rejecting the null hypothesis, it was established that community participation was a critical factor influencing the effectiveness of health centres. The findings implied that fostering strong partnerships with community members, incorporating their views in setting priorities, and creating feedback mechanisms enhanced the responsiveness, accountability, and quality of services.

4.4 Effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District

Table 6: Descriptive Statistics On accountability mechanisms and performance outcomes

Accountability mechanisms	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	STD
The health centre shared information on finances and resource use.	8 (7.0%)	8 (7.0%)	14 (12.3%)	28 (24.6%)	56 (49.1%)	4.02	1.241
Financial and service delivery records were properly maintained.	11 (9.6%)	18 (15.8%)	9 (7.9%)	27 (23.7%)	49 (43.0%)	3.75	1.400
Health centre staff were regularly supervised and monitored.	7 (6.1%)	10 (8.8%)	14 (12.3%)	21 (18.4%)	62 (54.4%)	4.06	1.257
Clear rules and guidelines governed staff conduct.	14 (12.3%)	20 (17.5%)	5 (4.4%)	28 (24.6%)	47 (41.2%)	3.65	1.469

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Corrective action was taken when staff failed to follow procedures.	5 (4.4%)	13 (11.4%)	9 (7.9%)	29 (25.4%)	58 (50.9%)	4.07	1.203

Source: Primary Data, 2025

Starting with the statement, "The health centre shared information on finances and resource use," the results indicated that respondents generally perceived transparency in financial management positively. Specifically, 28 respondents (24.6%) agreed, and 56 respondents (49.1%) strongly agreed, totaling 84 respondents or 73.7% of the sample who viewed the sharing of financial and resource information favorably. A smaller proportion of respondents expressed disagreement, with 8 respondents (7.0%) disagreeing and another 8 respondents (7.0%) strongly disagreeing, while 14 respondents (12.3%) remained neutral. The mean score of 4.02 suggested that, on average, participants recognized that health centres provided adequate information on finances, while the standard deviation of 1.241 indicated moderate variability in responses. This implied that, although most health centres were transparent, some respondents perceived gaps in financial disclosure, highlighting areas where accountability could be strengthened.

Respondents consistently reported that accountability mechanisms played a significant role in improving health centre performance. A Health Centre Manager explained, "We maintain records of all financial transactions, staff attendance, and service delivery logs. Regular audits and performance evaluations help identify gaps and ensure that responsibilities are met" (Source: KM006/12/08/2025). Assistant Managers noted that performance reports were conducted monthly, and the results were reviewed in staff meetings to inform corrective actions. One Medical Staff member shared, "Accountability practices, such as monitoring adherence to treatment protocols and reviewing patient records, have reduced errors and improved patient care outcomes" (Source: KM007/12/08/2025).

Challenges in enforcing accountability mechanisms were also highlighted. A Community Leader stated, "Sometimes it is difficult to implement sanctions or corrective measures when staff fail to follow procedures, especially when resources are limited or staff shortages exist" (Source: KM008/12/08/2025). Ministry of Health Officials corroborated this, noting that compliance with accountability standards depended heavily on staff commitment and consistent supervision (Source: KM009/12/08/2025). Overall, respondents indicated that strong accountability systems directly influenced service quality, efficiency, and trust between the health centre and the community.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
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Regarding the statement, "Financial and service delivery records were properly maintained," 27 respondents (23.7%) agreed and 49 respondents (43.0%) strongly agreed, totaling 76 respondents or 66.7% who perceived record-keeping as effective. Conversely, 18 respondents (15.8%) disagreed, 11 respondents (9.6%) strongly disagreed, and 9 respondents (7.9%) were neutral. The mean score of 3.75 and a standard deviation of 1.400 suggested that respondents' perceptions were moderately positive but somewhat dispersed, indicating variability in record-keeping practices across health centres. This implied that while record management generally supported accountability and informed decision-making, some centres may have faced challenges in maintaining consistent and accurate records.

For the statement, "Health centre staff were regularly supervised and monitored," 21 respondents (18.4%) agreed and 62 respondents (54.4%) strongly agreed, totaling 83 respondents or 72.8% who reported that supervision was adequately conducted. A smaller proportion of respondents disagreed (10 respondents, 8.8%) or strongly disagreed (7 respondents, 6.1%), while 14 respondents (12.3%) were neutral. The mean score of 4.06 and a standard deviation of 1.257 suggested generally positive perceptions of supervision, with moderate variability. This implied that regular monitoring contributed to maintaining service standards, promoting accountability among staff, and ensuring that health services were delivered effectively.

Regarding the statement, "Clear rules and guidelines governed staff conduct," 28 respondents (24.6%) agreed and 47 respondents (41.2%) strongly agreed, totaling 75 respondents or 65.8% in agreement. A significant proportion of respondents, however, expressed disagreement, with 20 respondents (17.5%) disagreeing and 14 respondents (12.3%) strongly disagreeing, while 5 respondents (4.4%) remained neutral. The mean score of 3.65 and a standard deviation of 1.469 indicated moderate agreement with considerable variability, suggesting that some health centres had well-defined conduct guidelines, whereas others may have lacked clarity or enforcement. This finding implied that establishing and enforcing clear rules was crucial for promoting professionalism and improving overall performance outcomes.

For the statement, "Corrective action was taken when staff failed to follow procedures," 29 respondents (25.4%) agreed and 58 respondents (50.9%) strongly agreed, totaling 87 respondents or 76.3% who reported that corrective measures were implemented. A smaller proportion of respondents disagreed (13 respondents, 11.4%) or strongly disagreed (5 respondents, 4.4%), while 9 respondents (7.9%) were neutral. The mean score of 4.07 and a standard deviation of 1.203 suggested a generally strong perception that health centres applied corrective actions consistently, with relatively low variability. This implied that the implementation of corrective measures reinforced accountability, promoted adherence to standards, and contributed positively to the performance of health centres.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Table 7: Regression Analysis between accountability mechanisms and performance outcomes at selected health centres in Kayunga District

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.692[a]	.479	.475	2.336
a. Predictors: (Constant), Accountability Mechanisms				

Source: Primary Data, 2025

The model summary indicated a correlation coefficient (R) of 0.692, suggesting a strong positive relationship between accountability mechanisms and performance outcomes. The R Square value of 0.479 indicated that approximately 47.9% of the variation in performance outcomes was explained by accountability mechanisms alone, while the adjusted R Square of 0.475 accounted for the sample size and the number of predictors, confirming a substantial explanatory power of the model. The standard error of the estimate was 2.336, reflecting the average distance between the observed performance outcomes and the regression line, which highlighted that the model had a reasonably good fit.

Table 8: Analysis of Variance

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	562.573	1	562.573	103.109	.000[b]
	Residual	611.085	112	5.456		
	Total	1173.658	113			
a. Dependent Variable: Performance Outcomes						
b. Predictors: (Constant), Accountability Mechanisms						

Source: Primary Data, 2025

The F-value of 103.109 with a corresponding significance level of 0.000 indicated that the regression model was statistically significant. This implied that accountability mechanisms, as a predictor, had a significant effect on performance outcomes at the selected health centres. Consequently, the null hypothesis, which stated that accountability mechanisms had no significant influence on performance outcomes, was rejected. The rejection of the null hypothesis provided empirical evidence that accountability mechanisms were a critical determinant of health centre performance.

Table 9: Coefficients

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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Coefficients						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.319	1.011		4.272	.000
	Accountability Mechanisms	.701	.069	.692	10.154	.000
a. Dependent Variable: Performance Outcomes						

Source: Primary Data, 2025

The coefficients table revealed the magnitude and direction of the effect of accountability mechanisms. The unstandardized coefficient (B) of 0.701 indicated that for every unit increase in accountability mechanisms, performance outcomes increased by 0.701 units, holding other factors constant. The standardized beta of 0.692 and the t-value of 10.154, with a significance level of 0.000, further confirmed that accountability mechanisms had a strong and statistically significant positive impact on performance outcomes. This suggested that health centres that implemented robust accountability measures such as transparent sharing of financial and resource information, proper maintenance of records, regular staff supervision, adherence to rules and guidelines, and prompt corrective actions experienced higher performance outcomes.

4.5 Relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

Table 10: Descriptive Statistics On Resource availability and performance outcomes

Resource availability	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Mean**	**STD**
The health centre had adequate numbers of health workers.	8 (7.0%)	6 (5.3%)	18 (15.8%)	26 (22.8%)	56 (49.1%)	4.02	1.226
Health workers had the required skills to deliver services.	5 (4.4%)	26 (22.8%)	9 (7.9%)	27 (23.7%)	47 (41.2%)	3.75	1.322
Essential medicines were consistently available.	11 (9.6%)	10 (8.8%)	13 (11.4%)	22 (19.3%)	58 (50.9%)	3.93	1.361

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Medical equipment was adequate and functional.	15 (13.2%)	23 (20.2%)	5 (4.4%)	23 (20.2%)	48 (42.1%)	3.58	1.516
Health centre infrastructure supported effective service delivery.	6 (5.3%)	5 (4.4%)	11 (9.6%)	32 (28.1%)	60 (52.6%)	4.18	1.118

Source: Primary Data, 2025

Starting with the statement, "The health centre had adequate numbers of health workers," the results indicated that respondents generally perceived staffing levels as sufficient. Specifically, 26 respondents (22.8%) agreed and 56 respondents (49.1%) strongly agreed, totaling 82 respondents or 72% of the sample who positively assessed the adequacy of health worker numbers. A smaller proportion of respondents disagreed (6 respondents, 5.3%) or strongly disagreed (8 respondents, 7.0%), while 18 respondents (15.8%) were neutral. The mean score of 4.02 suggested that participants generally perceived staffing levels as satisfactory, while the standard deviation of 1.226 indicated moderate variability in responses. This implied that while most health centres maintained adequate staffing, some respondents observed gaps that could affect service delivery. Adequate staffing was crucial for ensuring timely service provision and reducing the workload on individual health workers.

Respondents emphasized the critical role of resource availability in shaping service delivery. A Department Head remarked, "The availability of medicines, medical equipment, and qualified staff significantly determines how efficiently we provide care. When essential resources are in place, patient outcomes improve, and service delivery becomes more consistent" (Source: KM010/12/08/2025). Patients also shared their experiences, with one noting, "When there are enough staff and medicines, we are attended to promptly. Delays are minimized, and our concerns are addressed more effectively" (Source: KM011/12/08/2025).

Instances where resource shortages affected patient care were also highlighted. A Medical Staff member explained, "There have been occasions when we ran out of critical medicines, which delayed treatment and forced us to refer patients elsewhere. Equipment shortages, such as non-functional diagnostic tools, sometimes compromise the quality of care we can provide" (Source: KM012/12/08/2025). In response to these challenges, various strategies were reported. A Health Centre Manager stated, "We try to manage limitations through resource prioritization, borrowing from nearby facilities, and mobilizing community support for donations of

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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supplies or voluntary services" (Source: KM013/12/08/2025). These strategies mitigated the impact of limited resources, though respondents agreed that adequate and consistent provision of resources was essential for optimal performance outcomes.

Regarding the statement, "Health workers had the required skills to deliver services," 27 respondents (23.7%) agreed and 47 respondents (41.2%) strongly agreed, totaling 74 respondents or 65% who affirmed that staff possessed the necessary skills. Conversely, 26 respondents (22.8%) disagreed, 5 respondents (4.4%) strongly disagreed, and 9 respondents (7.9%) were neutral. The mean score of 3.75 and a standard deviation of 1.322 suggested moderately positive perceptions with some variability, indicating that while many health centres had skilled personnel, there were disparities in competency levels across different centres. These findings implied that continuous professional development and training were essential to maintain service quality and improve patient outcomes.

For the statement, "Essential medicines were consistently available," 22 respondents (19.3%) agreed and 58 respondents (50.9%) strongly agreed, totaling 80 respondents or 70.2% in agreement. Only 10 respondents (8.8%) disagreed, 11 respondents (9.6%) strongly disagreed, and 13 respondents (11.4%) were neutral. The mean of 3.93 and standard deviation of 1.361 suggested that the majority perceived medicines as generally available, though some variability indicated occasional stock-outs or inconsistencies in supply. This implied that consistent availability of essential medicines was a key factor in enabling health centres to deliver uninterrupted and effective services.

Regarding the statement, "Medical equipment was adequate and functional," 23 respondents (20.2%) agreed and 48 respondents (42.1%) strongly agreed, totaling 71 respondents or 62.3% in agreement. A notable proportion of respondents, however, disagreed (23 respondents, 20.2%) or strongly disagreed (15 respondents, 13.2%), while 5 respondents (4.4%) were neutral. The mean score of 3.58 and a relatively high standard deviation of 1.516 indicated considerable variability in perceptions, suggesting that adequacy and functionality of equipment varied across health centres. These findings implied that insufficient or malfunctioning equipment could hinder effective service delivery and negatively affect performance outcomes, highlighting the need for regular maintenance and resource allocation.

For the statement, "Health centre infrastructure supported effective service delivery," 32 respondents (28.1%) agreed and 60 respondents (52.6%) strongly agreed, totaling 92 respondents or 80.7% in agreement. Only 5 respondents (4.4%) disagreed, 6 respondents (5.3%) strongly disagreed, and 11 respondents (9.6%) were neutral. The mean score

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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of 4.18 and a standard deviation of 1.118 suggested strong agreement and relatively low variability, indicating that most respondents perceived health centre infrastructure as adequate to support effective service delivery. This implied that well-designed and maintained infrastructure contributed positively to the efficiency, accessibility, and quality of services provided to patients.

Table 11: Relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

Correlations			
		Resource Availability	Performance Outcomes
Resource Availability	Pearson Correlation	1	.749**
	Sig. (2-tailed)		.000
	N	114	114
Performance Outcomes	Pearson Correlation	.749**	1
	Sig. (2-tailed)	.000	
	N	114	114
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: Primary Data, 2025

The results indicated a strong positive relationship, with a Pearson correlation coefficient of 0.749, which was statistically significant at the 0.01 level ($p < 0.001$). This suggested that as the level of resource availability increased, performance outcomes at the health centres also improved. Specifically, health centres that had adequate numbers of skilled health workers, consistently available essential medicines, functional medical equipment, and supportive infrastructure were more likely to deliver timely, professional, and satisfactory services to patients. The statistical significance of the correlation implied that the observed relationship was unlikely to have occurred by chance, providing strong empirical evidence of the link between resources and service performance.

The results led to the rejection of the null hypothesis, which stated that there was no significant relationship between resource availability and performance outcomes. By rejecting the null hypothesis, it was established that resource

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425

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availability was a critical determinant of health centre performance. The findings also had practical implications for health management, as they suggested that investments in human, material, and infrastructural resources were essential for improving service delivery, ensuring consistency, enhancing professionalism, and increasing client satisfaction.

4.6 Performance outcomes at selected health centres in Kayunga District

Table 12: Descriptive Statistics On Performance outcomes at selected health centres in Kayunga District

Performance outcomes	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	STD
Patients were attended to in a timely manner.	7 (6.1%)	11 (9.6%)	14 (12.3%)	22 (19.3%)	60 (52.6%)	4.03	1.265
Health services were provided consistently.	10 (8.8%)	17 (14.9%)	13 (11.4%)	26 (22.8%)	48 (42.1%)	3.75	1.368
Health workers adhered to professional standards.	4 (3.5%)	11 (9.6%)	13 (11.4%)	21 (18.4%)	65 (57.0%)	4.16	1.172
Patients were treated with respect and dignity.	9 (7.9%)	16 (14.0%)	13 (11.4%)	28 (24.6%)	48 (42.1%)	3.79	1.334
Clients were satisfied with services provided.	8 (7.0%)	13 (11.4%)	8 (7.0%)	20 (17.5%)	65 (57.0%)	4.06	1.319

Source: Primary Data, 2025

Starting with the statement, "Patients were attended to in a timely manner," the results indicated that respondents generally perceived the timeliness of health services positively. Specifically, 22 respondents (19.3%) agreed, and 60 respondents (52.6%) strongly agreed, totaling 82 respondents or 71.9% of the sample who considered patient attendance to be prompt and efficient. A smaller proportion of respondents expressed disagreement, with 11 respondents (9.6%) disagreeing and 7 respondents (6.1%) strongly disagreeing, while 14 respondents (12.3%) remained neutral. The mean score of 4.03 suggested that, on average, participants viewed timely patient care favorably, and the standard deviation of 1.265 indicated moderate variability in responses. This implied that, while most health centres were perceived to attend to patients promptly, some inconsistencies in service delivery still existed, which may have affected patient experiences at certain centres. The findings highlighted the importance of adequate staffing,

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425
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effective scheduling, and efficient workflow processes to ensure that patients were attended to without unnecessary delays, which in turn could enhance patient satisfaction and trust in the health system.

Regarding the statement, "Health services were provided consistently," 26 respondents (22.8%) agreed and 48 respondents (42.1%) strongly agreed, totaling 74 respondents or 64.9% who reported that services were reliably delivered. However, 17 respondents (14.9%) disagreed, 10 respondents (8.8%) strongly disagreed, and 13 respondents (11.4%) were neutral. The mean score of 3.75 and a standard deviation of 1.368 suggested moderate positive perceptions, with notable variability in responses. This indicated that while many health centres maintained regular service delivery, some centres faced challenges that led to irregularities or interruptions in services. These findings implied that consistency in service delivery was critical for maintaining patient confidence, encouraging utilization of health services, and ensuring that health outcomes were not negatively affected by gaps in care. Health centres with inconsistent service delivery may need targeted interventions, such as improved supply management, staff scheduling, and standard operating procedures, to enhance reliability.

For the statement, "Health workers adhered to professional standards," 21 respondents (18.4%) agreed, and 65 respondents (57.0%) strongly agreed, totaling 86 respondents or 75.4% who perceived that staff largely followed professional guidelines and ethical practices. Only 11 respondents (9.6%) disagreed, 4 respondents (3.5%) strongly disagreed, and 13 respondents (11.4%) were neutral. The mean score of 4.16 and a standard deviation of 1.172 suggested generally strong agreement with relatively low variability, indicating that adherence to professional standards was observed consistently across most health centres. This implied that professional conduct played a significant role in maintaining the quality of health services, fostering patient trust, and promoting safe and effective care. The findings highlighted the need for continuous professional development, supervision, and adherence to regulatory standards to sustain high-quality service delivery and performance outcomes.

Regarding the statement, "Patients were treated with respect and dignity," 28 respondents (24.6%) agreed, and 48 respondents (42.1%) strongly agreed, totaling 76 respondents or 66.7% who reported that health workers provided respectful and dignified care. A smaller proportion of respondents disagreed (16 respondents, 14.0%) or strongly disagreed (9 respondents, 7.9%), while 13 respondents (11.4%) were neutral. The mean score of 3.79 and a standard deviation of 1.334 suggested moderately positive perceptions with some variability, indicating that while respectful treatment was generally provided, patient experiences differed across centres. This implied that respectful and dignified care was crucial for enhancing patient satisfaction, promoting positive health-seeking behaviors, and

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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ISSN: 3006-6425

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reinforcing trust in health facilities. Variations in this aspect of service delivery highlighted the need for ongoing training in patient-centered care and interpersonal communication for health workers.

For the statement, "Clients were satisfied with services provided," 20 respondents (17.5%) agreed and 65 respondents (57.0%) strongly agreed, totaling 85 respondents or 74.5% who were satisfied with the services received. A smaller proportion of respondents disagreed (13 respondents, 11.4%) or strongly disagreed (8 respondents, 7.0%), while 8 respondents (7.0%) were neutral. The mean score of 4.06 and standard deviation of 1.319 indicated that clients were generally satisfied with services, although experiences varied across different centres. This implied that client satisfaction was influenced by multiple factors, including timeliness, consistency, professionalism, and respectful treatment. Positive perceptions of service satisfaction were essential for promoting health centre utilization, adherence to treatment, and overall performance outcomes.

Table 13: Multiple Linear Regression Analysis between Resource Availability, Accountability Mechanisms, Community Participation and Performance Outcomes

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.759[a]	.576	.564	2.127
a. Predictors: (Constant), Resource Availability, Accountability Mechanisms, Community Participation				

Source: Primary Data, 2025

The model summary indicated a correlation coefficient (R) of 0.759, suggesting a strong positive relationship between the independent variables and performance outcomes. The R Square value of 0.576 indicated that approximately 57.6% of the variation in performance outcomes was explained by the combined influence of resource availability, accountability mechanisms, and community participation, while the adjusted R Square of 0.564 accounted for the number of predictors in the model, confirming a substantial explanatory power of the model. The standard error of the estimate was 2.127, reflecting the average distance of the observed performance outcomes from the regression line. Overall, these results suggested that the model provided a good fit for the data and that the predictors collectively had a significant impact on health centre performance.

Table 14: Analysis of Variance

ANOVA[a]

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	676.029	3	225.343	49.812	.000[b]
	Residual	497.629	110	4.524		
	Total	1173.658	113			
a. Dependent Variable: Performance Outcomes						
b. Predictors: (Constant), Resource Availability, Accountability Mechanisms, Community Participation						

Source: Primary Data, 2025

The ANOVA table showed a calculated F-value of 49.812 with a corresponding significance value ($p < 0.001$), indicating that the regression model was statistically significant. This implied that the independent variables, when taken together, significantly predicted performance outcomes at the selected health centres. Consequently, the null hypothesis, which stated that resource availability, accountability mechanisms, and community participation had no significant effect on performance outcomes, was rejected. The rejection of the null hypothesis confirmed that at least one of the predictors had a meaningful influence on performance outcomes, justifying further examination of individual contributions of each variable.

Table 15: Coefficients

Coefficients						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.818	1.060		4.714	.000
	Accountability Mechanisms	.485	.126	.283	2.867	.000
	Community Participation	.308	.165	.207	2.656	.000
	Resource Availability	.561	.176	.498	3.196	.000
a. Dependent Variable: Performance Outcomes						

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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Source: Primary Data, 2025

Resource availability had a positive and significant influence on performance outcomes, with an unstandardized coefficient (B) of 0.561, a standardized beta of 0.498, a t-value of 3.196, and a p-value of 0.000. This indicated that for every unit increase in resource availability, performance outcomes increased by 0.561 units, holding other factors constant. The results implied that health centres with adequate staffing, functional medical equipment, consistent availability of medicines, and supportive infrastructure experienced higher performance outcomes.

Accountability mechanisms also had a positive and significant impact on performance outcomes, with an unstandardized coefficient of 0.485, a standardized beta of 0.283, a t-value of 2.867, and a p-value of 0.000. This finding suggested that the presence of strong accountability systems, including financial transparency, proper record-keeping, regular staff supervision, adherence to rules, and corrective actions, contributed meaningfully to improved performance at the health centres. Similarly, community participation positively and significantly influenced performance outcomes, with a coefficient of 0.308, a standardized beta of 0.207, a t-value of 2.656, and a p-value of 0.000. This implied that involving community members and representatives in planning, decision-making, and feedback mechanisms enhanced responsiveness, service quality, and overall performance.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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CHAPTER FIVE

SUMMARY AND DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses summary and discussion of findings of the study, conclusion and recommendations in relation to the study findings and study objectives about the following study; the relationship between good governance practices and performance outcomes at selected health centres in Kayunga District.

5.1 Summary of findings

5.1.1 Relationship between Community participation and performance outcomes at selected health centres in Kayunga District

The study found a strong positive relationship between community participation and performance outcomes at the selected health centres, with a Pearson correlation coefficient of 0.716, which was statistically significant ($p < 0.001$). This indicated that higher levels of community involvement in planning, decision-making, and feedback processes were associated with improved service delivery and overall performance. The results led to the rejection of the null hypothesis, confirming that community participation was a critical determinant of health centre performance.

5.1.2 Effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District

The study found a strong positive relationship between accountability mechanisms and performance outcomes at the selected health centres, with a correlation coefficient (R) of 0.692 and R^2 of 0.479, indicating that accountability mechanisms explained approximately 47.9% of the variation in performance outcomes. The regression model was statistically significant ($F = 103.109$, $p < 0.001$), and the unstandardized coefficient (B) of 0.701 showed that a unit increase in accountability mechanisms led to a 0.701 increase in performance outcomes. These results led to the rejection of the null hypothesis, confirming that accountability mechanisms were a critical determinant of health centre performance.

5.1.3 Relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

The study found a strong positive relationship between resource availability and performance outcomes at the selected health centres, with a Pearson correlation coefficient of 0.749, significant at the 0.01 level ($p < 0.001$). It was established that health centres with adequate numbers of skilled health workers, consistent availability of essential medicines, functional medical equipment, and supportive infrastructure delivered more timely, professional, and satisfactory services. The results led to the rejection of the null hypothesis, confirming that resource availability was a critical determinant of performance outcomes.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

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5.2 Discussion of Findings of the Study

5.2.1 Relationship between Community participation and performance outcomes at selected health centres in Kayunga District

The study established that community participation played a pivotal role in influencing performance outcomes at selected health centres in Kayunga District. It was found that active engagement of community members in planning health centre activities was widely recognized as enhancing the alignment of services with local needs. Respondents indicated that involving community members allowed them to voice their priorities and concerns, thereby informing service delivery decisions. One Community Health Worker remarked that community participation helped ensure that activities such as maternal health campaigns and immunization drives addressed actual population needs. Similarly, a Local Government Official observed that participatory platforms, including health committees and feedback forums, improved accountability and service responsiveness. These findings were consistent with the Principal-Agent theory, which posits that in settings with multiple stakeholders and asymmetrical information, oversight and participatory mechanisms are critical to aligning the actions of agents, such as health facility staff, with the priorities of principals, such as the community and policymakers (Shleifer & Vishny, 1997; Eisenhardt, 1989). Without such mechanisms, agents may act in ways that do not fully meet community needs, highlighting the relevance of participatory processes in decentralized health systems like Uganda's.

It was further established that community representatives were actively involved in decision-making processes at the health centres. Respondents indicated that these representatives were consulted on governance issues, service priorities, and operational challenges. A Board of Governors member noted that community dialogues and suggestion boxes provided formal avenues for citizens to influence decision-making, fostering ownership and mutual accountability. This aligns with evidence from sub-Saharan Africa, where the establishment of grassroots leadership bodies and formal participatory structures was linked to improvements in service utilization, responsiveness, and resource management (Molyneux et al., 2012). The findings reinforced the theoretical proposition of the Principal-Agent framework that accountability mechanisms and oversight, through community participation, reduce information asymmetry and help ensure that agents' actions align with broader health system objectives.

The study also established that health centres actively sought community feedback and used it to improve service delivery. Respondents indicated that feedback informed adjustments to service provision, ensuring that interventions were relevant and responsive. A patient emphasized that participatory engagement resulted in services that were more attuned to local needs and priorities. This finding mirrored broader empirical evidence showing that participatory approaches in primary healthcare programs enhance performance by strengthening community ownership, fostering

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

mutual accountability between service users and providers, and improving service quality (Theodoratou et al., 2020; Gilson et al., 2017). Furthermore, qualitative studies in Uganda and Kenya have highlighted that persistent gaps in service quality, including inadequate outreach or unaddressed user complaints, could be mitigated through participatory governance mechanisms that institutionalize community engagement in health planning and monitoring (Nabirye et al., 2011; Molyneux et al., 2012).

5.2.2 Effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District

The study established that accountability mechanisms significantly influenced performance outcomes at selected health centres in Kayunga District. It was observed that health centres that shared information on finances and resource use were perceived to be more transparent and trustworthy by the community and staff. Respondents indicated that regular disclosure of financial and operational information promoted confidence in the management of resources and reinforced the alignment of staff actions with organizational goals. These findings aligned with the theoretical propositions of the Principal-Agent theory, which emphasizes that in settings characterized by multiple stakeholders and information asymmetries, clear oversight structures and institutionalized monitoring are essential to ensure that agents such as health facility staff act in accordance with the objectives of principals, including communities, policymakers, and funders (Shleifer & Vishny, 1997; Eisenhardt, 1989).

It was established that proper maintenance of financial and service delivery records contributed to accountability and informed decision-making. Respondents reported that well-organized documentation of transactions, staff performance, and patient records provided a reliable basis for monitoring and evaluating performance. This was consistent with prior studies highlighting that routine audits, structured record-keeping, and transparent reporting mechanisms improve both resource utilization and service delivery outcomes (Ahmed et al., 2020; Brinkerhoff & Bossert, 2014). One Health Centre Manager noted that maintaining accurate records facilitated the identification of gaps and enabled timely corrective actions, which ultimately enhanced patient care and overall health centre efficiency.

Regular supervision and monitoring of staff were also established as critical elements of effective accountability. Respondents indicated that structured oversight, including performance reviews and adherence checks, reinforced professional standards and reduced the likelihood of errors in service delivery. This finding resonated with the literature on institutionalized accountability, which emphasizes that supervision mechanisms ensure that agents act in accordance with organizational rules, thereby improving operational efficiency and service quality (Savedoff, 2010; World Bank, 2004). It was further established that corrective actions, when applied consistently, reinforced

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research
ISSN: 3006-6425
Vol. 5 Issue 3, March- 2026, Pages: 177-259

compliance with procedures, promoted ethical conduct, and mitigated risks associated with mismanagement or negligence.

The study also highlighted that clear rules and guidelines governing staff conduct were fundamental to accountability. Respondents noted that while some health centres had well-defined policies, others experienced gaps in clarity or enforcement. The observed variability suggested that institutionalization of explicit operational standards was necessary to ensure consistent performance outcomes. The literature supports this finding, demonstrating that transparent procedures, clearly defined roles, and structured oversight positively influence service delivery and resource utilization in low-resource settings (Ahmed et al., 2020; Brinkerhoff & Bossert, 2014).

5.2.3 Relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

The study established that resource availability was a critical determinant of performance outcomes at selected health centres in Kayunga District. It was observed that staffing levels, skills of health workers, availability of essential medicines, functional medical equipment, and supportive infrastructure significantly influenced service delivery. Respondents generally perceived that health centres with adequate numbers of health workers were better able to deliver timely and effective services, reduce waiting times, and ensure patient concerns were addressed efficiently. This finding was consistent with the literature indicating that human resources are foundational for the provision of quality healthcare, as adequate staffing enhances workload management, service coverage, and professional accountability (Amoako et al., 2017; Robinson et al., 2019).

It was further established that the skills and competence of health workers were essential for optimal performance. Respondents reported that when staff possessed the required qualifications and were continuously trained, service quality improved and patient outcomes were positively impacted. Conversely, disparities in competency across health centres highlighted the need for continuous professional development and training to maintain standards. These findings aligned with studies that have shown that investment in human resource capacity, including skills development and on-the-job training, is critical for sustaining service quality and improving patient care outcomes (Kiyemba et al., 2020).

The study also revealed that the consistent availability of essential medicines was central to service performance. Respondents indicated that shortages of critical drugs often delayed treatment, compromised patient care, and necessitated referrals to other facilities. Health centres that maintained reliable stocks of medicines were better able

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

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to provide uninterrupted services, reflecting the importance of supply chain management in health systems. This corroborated findings from Uganda and other low-resource contexts, where consistent drug availability was associated with increased antenatal care coverage, higher immunization rates, and improved overall service delivery (Kiyemba et al., 2020; WHO, 2019).

5.3 Conclusions

5.3.1 Relationship between Community participation and performance outcomes at selected health centres in Kayunga District

It was concluded that community participation played a crucial role in influencing performance outcomes at the selected health centres in Kayunga District. Active engagement of community members in planning health centre activities was widely recognized as improving the alignment of services with local needs. Respondents indicated that involving community members allowed them to express their priorities and concerns, which in turn informed service delivery decisions. It was found that participatory processes, such as community health committees and feedback forums, enhanced accountability and responsiveness, ensuring that programs like maternal health campaigns and immunization drives addressed actual population needs. These conclusions aligned with the Principal-Agent theory, which emphasizes that in contexts with multiple stakeholders and information asymmetries, participatory and oversight mechanisms are essential to ensure that the actions of agents, such as health facility staff, are consistent with the priorities of principals, including communities and policymakers. Without such mechanisms, agents may pursue their own agendas, highlighting the importance of community engagement in decentralized health systems.

The study further established that community representatives were actively involved in decision-making at the health centres. Respondents reported that these representatives were consulted on governance issues, service priorities, and operational challenges. Formal mechanisms, such as suggestion boxes and structured community dialogues, were perceived as effective avenues for citizens to influence decision-making, fostering ownership and mutual accountability. It was concluded that involving community representatives strengthened transparency, promoted alignment of service delivery with local needs, and reinforced the theoretical premise of the Principal-Agent framework that participatory oversight reduces information asymmetry and ensures agent actions support broader health system objectives.

5.3.2 Effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District

It was concluded that accountability mechanisms played a significant role in influencing performance outcomes at the selected health centres in Kayunga District. Health centres that consistently shared information on finances and resource utilization were perceived as more transparent and trustworthy by both staff and the community. Regular disclosure of operational and financial information was found to strengthen confidence in management practices,

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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enhance alignment between staff actions and organizational objectives, and promote a culture of responsible governance. These conclusions aligned with the Principal-Agent theory, which emphasizes that in environments with multiple stakeholders and information asymmetries, institutionalized monitoring and oversight structures are essential to ensure that agents act in the best interests of principals, including communities, policymakers, and funders.

It was further concluded that proper maintenance of financial and service delivery records was critical for fostering accountability and informing decision-making. Health centres that organized and maintained accurate records of transactions, staff performance, and patient care were better able to monitor outcomes, identify gaps, and implement timely corrective measures. Structured record-keeping, routine audits, and transparent reporting were found to enhance both resource utilization and service delivery efficiency. By ensuring that reliable information was available for oversight, health centres could make evidence-based decisions that improved patient care and operational performance.

Regular supervision and monitoring of staff were also concluded to be vital for effective accountability. Structured oversight, including performance reviews and adherence checks, reinforced professional standards, minimized errors, and promoted compliance with organizational rules. Corrective actions, when applied consistently, further strengthened adherence to procedures, promoted ethical conduct, and reduced risks associated with negligence or mismanagement. These findings highlighted that institutionalized supervision mechanisms are crucial for ensuring agents act in accordance with organizational objectives, thereby enhancing service quality and operational efficiency.

5.3.3 Relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

It was concluded that resource availability was a fundamental determinant of performance outcomes at the selected health centres in Kayunga District. Specifically, adequate staffing levels, the skills and competence of health workers, consistent availability of essential medicines, functional medical equipment, and supportive infrastructure collectively contributed to the effective delivery of health services. Health centres that maintained sufficient numbers of qualified staff were able to provide timely and efficient care, reduce patient waiting times, and respond effectively to community health needs.

It was further concluded that the competence and continuous professional development of health workers were essential for maintaining service quality and achieving positive patient outcomes. Variations in staff skills across

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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different health centres highlighted the importance of ongoing training and capacity-building initiatives to ensure consistent and high-quality healthcare delivery.

The study concluded that the availability of essential medicines played a critical role in sustaining uninterrupted health services. Health centres that managed to maintain adequate drug stocks were better positioned to deliver effective care, prevent treatment delays, and minimize the need for patient referrals.

5.4 Recommendations

5.4.1 Relationship between Community participation and performance outcomes at selected health centres in Kayunga District

It was recommended that there should be continuous and structured engagement of community members in all aspects of health centre planning and decision-making. Health centres should establish and maintain participatory platforms, such as community health committees, suggestion boxes, and regular feedback forums, to ensure that community priorities and concerns are consistently considered in service delivery. There should be mechanisms to encourage wider community involvement, including outreach initiatives to inform citizens about opportunities to participate and to enhance attendance in planning and feedback sessions.

It was also recommended that community representatives should be formally integrated into governance structures at health centres. There should be clear roles and responsibilities for these representatives to ensure meaningful participation in decision-making processes, including setting service priorities, monitoring performance, and providing oversight. Health centres should provide capacity-building opportunities for community representatives to strengthen their ability to engage effectively and contribute to improving service outcomes.

5.4.2 Effect of accountability mechanisms on performance outcomes at selected health centres in Kayunga District

It was recommended that there should be consistent implementation and strengthening of accountability mechanisms at all health centres. Health centres should ensure regular sharing of financial and operational information with both staff and the community to enhance transparency, build trust, and promote responsible governance. There should be formal procedures for timely disclosure of records on finances, resource utilization, and service delivery to reinforce alignment between staff actions and organizational objectives.

It was further recommended that health centres should maintain comprehensive and accurate records of transactions, staff performance, and patient care. There should be structured record-keeping systems, routine audits, and transparent

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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reporting processes to provide reliable information for decision-making and oversight. Health centres should ensure that these practices are institutionalized to enable timely identification of gaps, implementation of corrective measures, and evidence-based planning to improve service delivery outcomes.

Additionally, it was recommended that there should be regular supervision and monitoring of staff. Health centres should implement structured oversight mechanisms, including performance reviews, adherence checks, and consistent corrective actions, to promote compliance with organizational rules, ethical conduct, and professional standards.

5.4.3 Relationship between Resource availability and performance outcomes at selected health centres in Kayunga District

It was recommended that there should be deliberate efforts to ensure adequate resource availability at all health centres. Health centres should maintain sufficient numbers of qualified health workers to provide timely, efficient, and responsive care. There should be measures to optimize staffing levels, reduce workload pressures, and ensure that community health needs are met effectively.

It was further recommended that there should be continuous professional development and capacity-building initiatives for health workers. Health centres should provide ongoing training to enhance skills and competencies, ensuring consistent and high-quality healthcare delivery across all facilities. There should be structured programs to address skill gaps and support professional growth among staff.

Additionally, it was recommended that there should be consistent and reliable availability of essential medicines. Health centres should implement robust supply chain management systems to prevent stock-outs, sustain uninterrupted service delivery, minimize treatment delays, and reduce unnecessary patient referrals. Ensuring that medical equipment is functional and infrastructure is supportive should also be prioritized to strengthen overall performance outcomes.

5.5 Areas for further studies

Future studies could explore the long-term effects of community participation on specific health outcomes, such as maternal and child health, immunization coverage, and disease prevention. While this study established a positive relationship between community engagement and performance outcomes, longitudinal research could provide insights into how sustained participatory practices influence measurable health indicators over time and whether gains are maintained or diminish without continuous engagement.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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Further research could investigate which forms of community participation such as health committees, feedback forums, suggestion boxes, or digital platforms are most effective in improving service delivery. Comparative studies across multiple health centres could identify best practices and contextual factors that enhance or hinder participatory mechanisms. This would help policymakers and facility manager's design more targeted engagement strategies that maximize performance outcomes.

Although this study highlighted the role of accountability in performance outcomes, future research could examine the relationship between accountability mechanisms and health worker motivation, job satisfaction, and retention. Qualitative and quantitative analyses could provide insights into how transparency, supervision, and corrective actions affect staff behavior, morale, and long-term commitment to health service delivery.

Further studies could explore the optimal allocation of resources including staffing, medicines, equipment, and infrastructure to improve efficiency and patient outcomes. Research could examine how resource distribution affects service quality, waiting times, and patient satisfaction, as well as how health centres can balance limited resources while meeting community health needs. This could include cost-effectiveness analyses to guide budgetary and logistical planning.

5.6 Contributions to the study

The study contributed to understanding how active community participation influenced performance outcomes at health centres. It established that engaging community members in planning, decision-making, and feedback processes improved alignment of services with local needs, enhanced accountability, and promoted responsiveness. This finding added to the literature on participatory governance in decentralized health systems and highlighted the practical relevance of the Principal-Agent theory in aligning the priorities of health facility staff with community expectations.

The study provided empirical evidence on the critical role of accountability mechanisms in enhancing performance outcomes. It established that transparency in financial management, proper maintenance of records, regular supervision, and corrective actions positively influenced service delivery. This contribution reinforced theoretical perspectives on institutionalized oversight and offered practical insights into how structured accountability frameworks can improve efficiency, professionalism, and trust in health service provision.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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The study highlighted the importance of adequate resources, including staffing levels, skills of health workers, essential medicines, functional medical equipment, and supportive infrastructure, in determining the effectiveness of service delivery. It established that resource availability directly affected the quality, timeliness, and reliability of health services, thereby contributing to a deeper understanding of how material and human resource inputs shape performance outcomes in primary healthcare settings.

The study offered practical contributions by identifying key areas where health centre managers and policymakers could focus to improve performance. It established that strategies promoting community engagement, institutionalized accountability, and optimal resource allocation were critical for enhancing health service quality. These contributions provided actionable guidance for local government authorities, health administrators, and development partners in designing interventions aimed at strengthening health centre performance.

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

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APPENDICES

Appendix I: Self-Administered Questionnaire

I Kusaasira Racheal, a student at Metropolitan International University, pursuing a Master's Degree in Public Administration. As part of my academic requirements, I conducted a study titled "Good Governance and Performance of Health Centres in Kayunga District: A Case Study of Selected Health Centres in Kayunga District." I kindly requested participants' involvement in this study as respondents. All information provided was treated with strict confidentiality and was only accessed by the research team. Thank you very much for your time and cooperation.

Yours Cordially,

SECTION A: Background Information	Options
Gender	☐ Male ☐ Female
Age group	☐ Below 25 ☐ 25–34 ☐ 35–44 ☐ 45 and above
Role at the health centre	☐ Health worker ☐ Administrator ☐ Community representative
Years of service/association with the health centre	☐ Less than 1 year ☐ 1–5 years ☐ 6–10 years ☐ Above 10 years

Section B:

In this section, please tick in the box that best describes your feelings on the proposition given. The rating is weighted as: Strongly Agree (SA) - 5; Agree (A) – 4; Neutral (N) -2; Disagree (D)-2 Strongly Disagree (SD)-1.

Community Participation

Community Participation	**1**	**2**	**3**	**4**	**5**
Community members participated in planning health centre activities.					
Community representatives were involved in health centre decision-making.					
Community views were considered when setting health centre priorities.					

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The health centre provided opportunities for community feedback.					
Community feedback was used to improve health service delivery.					

Accountability Mechanisms

Accountability Mechanisms	**1**	**2**	**3**	**4**	**5**
The health centre shared information on finances and resource use.					
Financial and service delivery records were properly maintained.					
Health centre staff were regularly supervised and monitored.					
Clear rules and guidelines governed staff conduct.					
Corrective action was taken when staff failed to follow procedures.					

Resource Availability

Resource Availability	**1**	**2**	**3**	**4**	**5**
The health centre had adequate numbers of health workers.					
Health workers had the required skills to deliver services.					
Essential medicines were consistently available.					
Medical equipment was adequate and functional.					
Health centre infrastructure supported effective service delivery.					

Performance Outcomes at Health Centres

Performance Outcomes	**1**	**2**	**3**	**4**	**5**
Patients were attended to in a timely manner.					

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**

Metropolitan Journal of Academic Pedagogical Research

ISSN: 3006-6425

Vol. 5 Issue 3, March- 2026, Pages: 177-259

Health services were provided consistently.					
Health workers adhered to professional standards.					
Patients were treated with respect and dignity.					
Clients were satisfied with services provided.					

APPENDIX II: INTERVIEW GUIDE

Introduction

I am conducting a study on good governance and performance of health centres in Kayunga District. Your responses washelp in understanding factors that influence health centre performance. All information was treated confidentially, and your participation was voluntary.

Section A: Background Information

1. What is your role at this health centre?
2. How long have you been working or associated with this health centre?
3. What is your gender?
4. Which age group do you belong to?

Section B: Community Participation and Performance Outcomes

1. How are community members involved in decision-making at this health centre?
2. Can you describe any initiatives that encourage community participation in health service delivery?
3. How has community participation affected the quality or efficiency of services provided at this centre?
4. In your opinion, what challenges exist in ensuring effective community involvement?

Section C: Accountability Mechanisms and Performance Outcomes

1. What accountability systems or practices are in place at this health centre?
2. How often are performance reports or evaluations conducted?
3. Can you give examples of how accountability measures have influenced service delivery?

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4. What challenges do you face in implementing or enforcing accountability mechanisms?

Section D: Resource Availability and Performance Outcomes

1. How would you describe the availability of resources (staff, equipment, medicines) at this health centre?
2. How do resource levels affect service delivery and overall performance?
3. Have there been instances where lack of resources impacted patient care or outcomes? Please explain.
4. What strategies have been used to manage resource limitations?

Received: 12.03.2026 **Accepted: 16.03.2026** **Published on: 30.03.2026**